

duodenoscopy (OGD) which revealed blood in the stomach (the neo-esophagus). The patient had a cardiac arrest before finding the source of the bleeding; hence, the OGD was aborted and cardiopulmonary resuscitation (CPR) commenced. He responded to one cycle of CPR and was intubated and fluid resuscitated. When hemodynamically stable, a computed tomography aortography (CTA) was performed, which demonstrated an aorto-esophageal fistula (AEF) and no other aortic abnormality. A rapid decision was made to proceed with a thoracic endovascular repair of the aorta (TEVAR) limited to that segment of aorta. The procedure was successful. He had a follow-up OGD weeks later which was normal. Four months later, he represented to hospital with hypovolemic shock secondary to massive hematemesis. Again, a diagnosis of AEF was confirmed on CTA, which was just proximal to the previous aortic stent graft. He again had emergency TEVAR covering the descending aorta from the level just below the left subclavian artery to just proximal to the celiac artery, which was again lifesaving and uncomplicated. Three months later, a repeat OGD revealed a large gastric ulcer with a visible segment of aortic stent graft in the base. At this time, he reported no symptoms and had a normal full blood count. He was then referred urgently to have definitive upper gastrointestinal and descending aorta repair. He underwent a thoracotomy, left heart bypass, repair of aorto-gastric fistula with primary stomach repair, and thoracic and abdominal aorta replacement with a Dacron graft. He made good recovery. His stent graft culture grew *Candida albicans* and vancomycin-resistant enterococcus.

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### The Importance of Computed Tomography Angiography before Bronchial Artery Embolization in Hemoptysis

**Afra Alfalahi, Mohannad Aftan, Yasir Jamil, Olena Gorobchuk, Eman Mohyeldin, Hozaifah Ali Akbar, Ayman Alsibaie**

Rashid Hospital and Trauma Center, Dubai Health Authority, Dubai, United Arab Emirates.

E-mail: a.s.maisem@gmail.com

**Educational Poster Background:** Massive hemoptysis is an emergency and a life-threatening situation. Computed tomography angiography helps in identifying the underlying pathology and anatomical variation of the bronchial artery. Imaging prior bronchial artery embolization has crucial role in directing an interventional radiologist. The bronchial artery is responsible for majority of hemoptysis cases. Lack of pre-embolization imaging assessment may result in recurrence or incomplete embolization. This poster demonstrates the following: imaging techniques using computed tomography angiography to identify the bronchial artery anatomic variations, procedure planning by identifying the site of bleeding and possible complication.

## P543

### Hemoptysis on Tuberculosis Sequelae: From the Physiopathology to the Endovascular Treatment

**Sylvie Sougoulouman Kolani, Meryem Haloua, Youssef Alaoui Lamrani, Meryem Boubbou, Mustapha Maaroufi**

Hassan II University Hospital, Fez, Morocco.

E-mail: kolanisylvie@gmail.com

**Educational Poster Background:** Pulmonary tuberculosis is still a deadly endemic infection in most developing countries. In 2015, the incidence of tuberculosis in Morocco was 89/100,000/year. Parenchymal sequelae are frequent presenting as cavitation, cicatricial fibrosis, and parenchymal destruction. Airways lesions often associated are paracatricial bronchiectasis, tracheobronchial stenosis, and broncholithiasis. Hemoptysis is systemic in these cases and due to bronchial artery hypervascularization. Since described in 1974, bronchial artery embolization (BAE) in controlling bleeding has improved in terms of technique and efficacy. It is indicated generally in mild to massive, life-threatening hemoptysis. Embolization's aim is to devascularize the hypervascular territory or at least decrease the hyperemia. The principal vascular occlusion's agents used nowadays are microparticles. Others additional agents are coils for proximal occlusion and liquids agents that require specific training. Hemoptysis on tuberculosis sequelae is due to systemic hypervascularization and bronchopulmonary shunt. Angio-computed tomography with acquisition at an aortic phase allows the detection of the hemorrhage site by searching for "ground glass" zones, and the visualization of bronchopulmonary sequelae. Arguments sustaining the hemoptysis's systemic origin are the dilatation of the bronchial artery, visualization of an early enhancement of pulmonary artery which is a sign of the bronchopulmonary shunt. Selective embolization of the systemic arteries bronchial or collateral such as intercostal, internal mammary artery, and diaphragmatic artery is indicated in case of life-threatening bleeding. Nowadays, the agents of choice are particles. Their size should be above 325  $\mu\text{m}$  so that they do not cross bronchopulmonary anastomoses. The immediate clinical efficacy varies between 70% and 99% with a great percentage of recurrence between 12% and 57%. Despite high recurrence rates, BAE is still the first-line, minimally invasive treatment of hemoptysis in emergency and within surgically unfit patients. Complications are rare (1%). The most severe are spinal ischemia and pulmonary embolism.

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### Percutaneous Augmentation Procedures in Chronic Compression Fractures of Dorsolumbar Spine

**Deep Narayan Srivastava**

All India Institute of Medical Sciences, New Delhi, India.

E-mail: drdeepsrivastava@gmail.com

**Objectives:** To evaluate the efficacy of percutaneous balloon vesselplasty in nontraumatic vertebral fractures of the thoracolumbar spine and compare it with percutaneous vertebroplasty. **Methods:** Fifty patients with chronic vertebral compression fracture of more than 12 weeks, severe pain (visual analog scale: more than/equal to 7) and disability attributable to the vertebral fracture were included and underwent vertebral augmentation procedures. Clinical and imaging follow-up was done for the two groups and evaluated for pain, disability scores, increase in anterior vertebral body height, and volume of cement injected. Complication rate was also compared in two groups. **Results:** Mean decrease in pain score was 4.29 in vertebroplasty group and 4.47 in the vesselplasty group. The mean increase in the