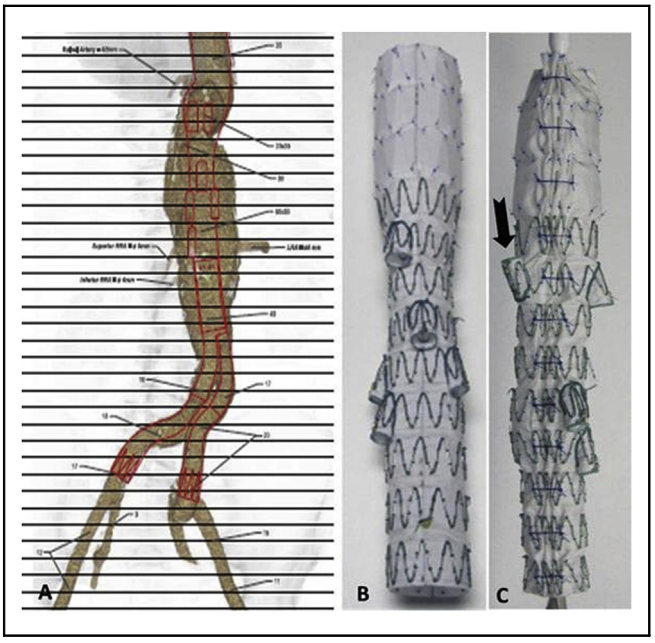
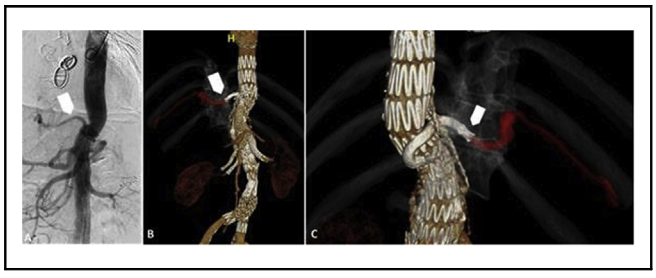
of the bridging covered stent to the origin of the vessel at 9:30 o'clock with a lower risk of kinking.
Bilateral femoral and right brachial artery access was used. The intercostal artery was catheterized and connected to the retrograde branch from femoral access successfully.
Results: Selective angiography of the target vessels and final angiography demonstrated good sealing and unimpeded branch-perfusion, without endoleak. The patient was discharged from hospital to home on postoperative day 10 without complications.
Six-month-follow up CTA demonstrated unchanged well-fitting endo-graft-position with good sealing and patency of all six branches including the two branches on the right renal artery and the branch to the intercostal artery (Figure. 5). The TAAA-diameter had significantly decreased from 60mm to 42mm and no signs of endoleak were present.
Conclusion: Branched endovascular aortic repair with a branch to a large intercostal artery was technically feasible and clinically successful.



[Custom made device with six branches]


[Final angiography and Post operative CTA]

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O-281 Total Endovascular Management of a Symptomatic Post-dissection Thoracoabdominal Aneurysm with the New Physician Modified Fenestrated Thoracic Endograft

Case Reports

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Introduction: The total endovascular management of thoracoabdominal and complex abdominal aortic aneurysms has recently become a valuable alternative to open surgery with acceptable morbidity and mortality rates.[1] However, due to the anatomic variability of the origin of the visceral aortic vessels, it requires customized, patient-specific endovascular devices. The high planning complexity and the long manufacturing time exclude the availability of this option in urgency setting. In order to overcome this limit, some centers started growing their own experience with the physician modified fenestrated endografts where thoracic grafts are fenestrated on the bench and then deployed into the diseased aorta.[2] We present the first case of a symptomatic post-dissection thoracoabdominal aneurysm treated with the homemade fenestration of the new Valiant Navion thoracic endograft (Medtronic).
Methods: A chronic post-dissection thoracoabdominal aneurysm (70 mm of diameter) of a 66-year-old woman was planned to be treated with a double stage procedure (first stage thoracic coverage of the proximal tear and second stage abdominal fenestrated endograft) in order to lower the risk of paraplegia.
Patient's history revealed active smoking, hypertension, myocardial infarction with a previous CABG. Due to the narrowness of both iliac access, the first stage was performed with the deployment of two low-profile Valiant Navion tapered endografts (proximal 37x31x207 mm, distal 34x28x207 mm) into the true lumen of the thoracic aorta. The first post-operative days were uneventful, however, one week later, the patient presented dyspnea and thoracic pain. The CT scan showed the thoracic aneurysm growth (90 mm of diameter), due to the pressurization of the false lumen, with pleural effusion and the collapse of the left lung.
Results: The rapid evolution of the aorta and the ongoing symptoms did not allow to wait for the custom-made endograft. For this reason, a 3D printed model of the aorta was prepared and a physician modified fenestrated endograft was planned.
A Valiant Navion endograft (31x31x184mm) was prepared with four reinforced fenestrations and, after a bilateral femoral exposure, was implanted into the dissected aorta. Visceral vessels were therefore engaged and relined with

four covered balloon expandable stents (BeGraft, Bentley). The hospitalization was uneventful and the CT scan before the discharge showed the patency of all the visceral vessels with a residual type IIIc endoleak from the superior mesenteric artery.

Conclusion: Modifying TEVAR grafts is a highly technical process requiring meticulous planning and extensive elective experience with FEVAR. In urgent setting, it could be a feasible alternative to open surgery in fragile patients.

Disclosure: Nothing to disclose

O-282 Superficial Venous Thrombosis Associated with Emergency Contraceptive Pill Usage (Levonorgestrel) – Case Report and Review of Literature

Case Reports

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Introduction: The association between contraceptive pill and venous thromboembolism (VTE) is well documented. Currently, Levonorgestrel used in combined contraceptive pill is considered to have lower risk of venous thromboembolism compared to other hormonal combinations. Progesterone only contraceptive pill and emergency contraceptive pills are considered not to increase the risk of VTE and are recommended for patients who are at high risk of VTE or with previous history of VTE. The aim of this paper is to present our experience in manging two patients with superficial venous thrombosis associated with progesterone only emergency contraceptive pill (Levonorgestrel) and review the literature.

Methods: Case 1: A 25-year-old female presented with a 2-day history of pain and discomfort in the left thigh. She does not have significant past medical history and has taken emergency contraceptive pill (1.5 mg of Levonorgestrol) three days ago. Clinical examination revealed tenderness over the lower and medial aspect of left thigh along the great saphenous vein. Venous doppler confirmed thrombus in the great saphenous vein extending for a short segment in the left thigh. She was treated with low molecular weight heparin for 5 days followed by 6 weeks course of Dabigatran 150 mg twice daily. Repeat venous doppler at one week did not reveal extension of thrombus into the deep veins.

Case 2: A 21-year-old female presented with a 3-day history of pain, swelling and skin discoloration over the left leg and thigh. She has taken emergency contraceptive pill (1.5 mg of Levonorgestrel) five days ago. She is otherwise fit and active without any significant past medical history. Clinical examination revealed multiple patches of skin discoloration over the thrombosed veins in the left leg and thigh. Venous doppler showed superficial venous thrombosis without any evidence of deep venous thrombosis. Venous doppler was repeated at one week, confirming lack of extension into the deep veins. She was treated with low molecular weight heparin for 5 days followed by 6 weeks course of Dabigatran 150 mg twice daily.

Results: Literature review was performed using PubMed search engine from 1992 to 2019 with the keyword's levonorgestrel and venous thromboembolism. The search retrieved 36 articles, which compared the risk of deep venous thrombosis with levonorgestrel with other combined contraceptive pills. Levonorgestrel is considered to have lower risk of venous thromboembolism compared to other hormonal contraceptives. No article was found on the association between isolated superficial venous thrombosis and high dose levonorgestrel used as emergency contraceptive pill.

Conclusion: Usage of high dose Levonorgestrel (emergency contraceptive pill) can be associated with Isolated superficial venous thrombosis. To our knowledge, this association has not been reported before. In our experience, it can be managed similar to other causes of superficial venous thrombosis with 6 weeks of anticoagulation. The role of thrombophilia screen, risk of recurrence and alternative contraceptive methods in these patients is unknown.

Disclosure: Nothing to disclose

O-283 Retroperitoneal Fibrosis Secondary to the Placement of Aorto-iliac Stents

Case Reports

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Introduction: Retroperitoneal fibrosis (RF) is a rare disorder characterized by inflammation and fibrosis in the periphery of the abdominal aorta (1). In about two thirds of the cases this condition is idiopathic (2). It is known that inflammatory aneurysms could be associated with RF and regression of periaortic inflammation after endovascular treatment (EVAR) of the aneurysm was described (3). However, very little is known about the possibility of this condition being associated with the implantation of endovascular devices. In the literature there is only one report of a clinical case in which the RF was secondary to the implantation of a kissing stent of the common iliac arteries (4). Periaortitis and periaortic fibro-inflammatory alterations secondary to stent graft implantation in the correction of abdominal aortic aneurysms have also been demonstrated, with 5 cases described in the literature (5,6,7,8,9). In some of these cases, patients presented complications of RF, such urethral obstruction with hydronephrosis. Possibly, since the symptoms of the disease are non-specific, the condition tends to be underreported and underdiagnosed. The pathophysiology of this pathological process is not known; however, it was proposed that the angioplasty and stenting can disturb plaque integrity with antigen exposure, triggering a local inflammatory response (10).