thrombus, collateral branch thrombosis. We used a new concept of stent, the Multilayer Flow Modulator (MFM*) to treat An. and try to avoid some drawbacks encountered with endografts.

Methods: This MFM* is a 3 Dimensional braided tube made of several inter-connected layers without any covering. Our earliest in vitro (theoretical simulation, computerized Fluid dynamics, Molecular Modelization) and in vivo demonstrate that this MFM* reduces the velocity in the aneurismal sac up to 90% by modifying the hemodynamic conditions. A saccular aneurysm without collateral branch will thrombose quickly. If a collateral branch is present the flow is directed towards this branch leading to shrinkage of the aneurysm. Animal experiments show excellent results. Moreover, as demonstrated in animal and human studies this MFM* preserves the collateral branches allowing the possibility to cover any artery without compromising the flow (renal, digestive arteries, supra aortic vessels…)

Results: 44 peripheral An. (iliac:23, femoral:1, popliteal:5, renal:8, mesenteric:2, carotid:2, subclavian:2, Caeliac trunk: 1) were treated with the MFM* (male:11, mean age 62±2 yrs) (57 stents 6 to 14 mm; length 40 to 120 mm) were implanted to treat these aneurysms, by femoral approach (39 cases), brachial approach (1 case). Technical success in all patients. No complications. An. thrombosed with diameter reduction in some pts. The thrombosis could take several weeks depending on the importance of the feeding vessels in view of preoperative embolization before surgery in all cases MR venogram was done within 24 hrs before retrieval of the filter. In conventional contrast venogram, if the filter is patent and free from significant clot burden (< 25% filled), Valsalva maneuver is then performed. Success of retrieval was defined as complete and intact whole filter removal. Complications during the procedure of retrieval like failure to remove the filter, distortion of the filter, migration of filter, presence of thrombus in the filter, local puncture site hematoma were noted.

Conclusions: A new concept of stent, the Multilayer Flow Modulator (MFM*) is developed to treat asymptomatic (30 - 55 %) but sometimes they present with cyanosis, dyspnea on exertion, neurological symptoms (migraine, vertigo, TIA, paresis, numbness, syncope, confusion, cerebral abscess, seizures) or haemoptysis and haemothorax. Diagnosis is confirmed by the characteristic (radiologic) echocoloic abnormalities on CT / coronal MRI. Hemoptysis, Pneumomucosa, locobectomy, local excision and ligation of the pulmonary artery used to be the available treatment but carried a significant morbidity and mortality. Currently Endovascular Treatment is emerging as a promising alternative and our series is perhaps the largest one.

Methods: The diagnosis is confirmed by angiography, which is performed in many views to delineate the point of communication. Long sheath is introduced and a Berman catheter is then advanced via the long sheath and the balloon is inflated. The flow across the BPF guides the balloon catheter to the branch supplying the BPF. The balloon is inflated either by coil embolization (Bioptome assisted) or Amplatzer large flow occluding device. The Fistula is closed either by coil embolization ( Bioptome assisted ) or Amplatzer device. A contrast venogram, if the filter is patent and free from significant clot burden (< 25% filled), Valsalva maneuver is then performed. Success of retrieval was defined as complete and intact whole filter removal. Complications during the procedure of retrieval like failure to remove the filter, distortion of the filter, migration of filter, presence of thrombus in the filter, local puncture site hematoma were noted.

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Results: 5 PA were treated with the MFM* (male: 5, mean age: 63 yrs) 9 stents (Ø6 to 8 mm, length 40 to 120 mm) were implanted by percutaneous ipsilateral femoral approach through 8F sheath. Technical success in all patients. All aneurysm thrombosed. Mid-term follow up will be presented. No stent fracture. This MFM* seems well indicated for this popliteal location.

Conclusions: A new concept of stent, the MFM* is developed to treat aneurysm. It opens a new approach to treat peripheral aneurysms avoiding most of the complications encountered with current endovascular techniques. The results obtained seem promising. A larger study is ongoing.

Methods: We wanted to study the feasibility and safety of IVC filters retrieval in patients with DVT with pulmonary thromboembolism (PTE) with IVC filter. We retrospectively analyzed the data of patients who presented with DVT with massive or submassive PTE and were treated with catheter thrombolysis and IVC filter (Eclipse vena caval filter from Bard company) implantation in our unit in the year 2012 -2013. CT pulmonary angiogram, venous colour Doppler and in some cases MR venogram was done within 24 hrs before retrieval of filter. In conventional contrast venogram, if the filter is patent and free from significant clot burden (< 25% filled), Valsalva maneuver is then performed. Success of retrieval was defined as complete and intact whole filter removal. Complications during the procedure of retrieval like failure to remove the filter, distortion of the filter, migration of filter, presence of thrombus in the filter, local puncture site hematoma were noted.

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