Stent assisted coil embolisation of a giant common hepatic artery aneurysm by using a self-expanding neurointerventional stent

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Disclosure

Speaker name:

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I have the following potential conflicts of interest to report:

- Consulting
- Employment in industry
- Stockholder of a healthcare company
- Owner of a healthcare company
- Other(s)

- I do not have any potential conflict of interest
A 75-year-old man with right upper quadrant pain underwent abdominal CT examination, showing a 43 mm partially calcified and thrombosed fusiform giant common hepatic aneurysm.

He had a cholecystectomy and ERCP history.
Due to localisation of the aneurysm stent-assisted coiling for flow preservation was decided and 3 days prior to intervention a dual anti-platelet medication started.

With right femoral approach, we first perform a diagnostic angio with a Simmons catheter.
After diagnostic angio, celiac trunk catheterized with 7F RDC I guiding catheter.

First we pass the aneurysm with Vasco 28 microcatheter for stent implantation.

Then we jailed a Headway 17 microcatheter into the aneurysm for coils.
First we coiled the aneurysm to give support to the stent, to prevent the stent from falling into the aneurysm.
After reaching a tight coil packing of the inferior part of the aneurysm we deploy a 5.5mmx75mm self expanding LEO stent.
Our microcatheter was jailed into the aneurysm so we kept going coiling for the upper part of the aneurysm.

At final control image the aneurysm was completely closed and flow to the hepatic arteries were preserved.
At 1 month control CTA, aneurysm was totally excluded, and the stent was open.
Hepatic artery aneurysms are rare and presentation with intraabdominal haemorrhage is associated with a high mortality rate.

The combined use of self-expandable stents with detachable coils for the treatment of visceral artery aneurysms is a feasible and safe method.

Flow-preservation to the organs is probably the best advantage.
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