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OPTIMIZING EMBOLIC THERAPY
in Challenging Cases
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Embolization of Transarterial Type II Endoleak Using Interlock™ Detachable Coils

BY GUSTAVO S. ODERICH, MD; BERNARDO C. MENDES, MD; AND MARIO D’ORIA, MD

A 85-year-old man presented to outpatient consultation with a persistent type II endoleak 4 years after endovascular aneurysm repair for an infrarenal abdominal aortic aneurysm. Previous medical history included coronary artery disease, pulmonary hypertension, and stage 3 chronic kidney disease. CT angiography revealed a type II endoleak originating from the inferior mesenteric artery (IMA). There was significant enlargement of the aneurysm sac, which measured up to 6.5 cm in the maximal transverse diameter, compared to 6.2 cm and 5.1 cm 1 and 2 years prior to presentation, respectively. Presence of the type II endoleak was confirmed by contrast-enhanced ultrasound (CEUS), which revealed retrograde filling from the IMA (Figure 1).

PROCEDURE

Under general endotracheal anesthesia, the patient was positioned supine, and right percutaneous femoral access was achieved. The superior mesenteric artery (SMA) was selectively catheterized, and contrast injection revealed flow into the IMA via collaterals, confirming the presence of a large type II endoleak originating from the IMA (Figure 2). Using a Renegade® STC Microcatheter (Boston Scientific Corporation) and a Glidewire® Gold hydrophilic guidewire (Terumo Interventional Systems), the middle colic artery and IMA were selectively catheterized. The microcatheter was then advanced into the aneurysm sac, which was excluded using numerous Interlock™-18 Detachable Coils (Boston Scientific Corporation). The proximal IMA was also embolized using Interlock™-18 Detachable Coils. Completion angiography revealed successful exclusion of the IMA with no evidence of residual endoleak (Figure 3). The postoperative course was uneventful, and the patient was discharged home on postoperative day 1.

DISCUSSION

Endoleaks are the most common event after endovascular aneurysm repair; lifelong surveillance is recommended because their persistence may lead to aneurysm sac expansion and aortic rupture.1 Treatment of type II endoleak has been a topic of significant controversy. Support for conservative management derives from the estimated low risk of late rupture secondary to isolated type II endoleak.2 However, while some authors have argued that prophylactic embolization in selected patients can decrease the risk of persistent type II endoleak and aneurysm sac growth,3 most would use a strategy of selective secondary intervention in the presence of significant aneurysm sac expansion, which is supported by current guidelines.4 Access to the aneurysm sac can be achieved via multiple approaches depending on type II endoleak location and delineation based on preoperative imaging. The transarterial approach usually represents the first-line option.5 When the IMA is involved, an SMA-to-IMA access (via the arc of Riolan or marginal artery of Drummond) may be chosen. Once stable access is achieved and an introducer sheath can be advanced in the proximal SMA, a floppy system composed of a microcatheter and microwire (similar to the combination utilized in the presented case) is preferred to navigate through the collateral into the IMA and the aortic aneurysm sac. Alternatively, the authors have found the 0.014-inch Fathom™ Steerable Guidewire (Boston Scientific Corporation) to have excellent steerability.

Complete obliteration of the endoleak nidus with elimination of all inflow and outflow vessels is required.

Figure 1. Preoperative CT angiogram (A) and CEUS (B) demonstrated the presence of type II endoleak with retrograde flow from a patent IMA (arrows).
OPTIMIZING EMBOLIC THERAPY in Challenging Cases

to prevent recurrence and can be achieved with different materials, typically a combination of plugs, coils, and/or Onyx™ liquid embolic (Medtronic). One benefit of Onyx™ is its ability to advance beyond the site of delivery and disperse through the endoleak nidus to fill the ingress and egress vessels. Being radiopaque, it can be closely followed under fluoroscopic guidance, and injection may be stopped if there is inadvertent nontarget delivery. Coils represent a feasible alternative, allowing for easy trackability during the procedure and quick placement within small vessels. In the case described in this article, the choice of coils was based on their accurate deployment and control because of the detachable mechanism and polyethylene terephthalate fibered structure, which is highly thrombogenic and provides a uniquely stable, permanent platform for blood stasis, thrombus organization, and neointima formation. To avoid persistent flow through the coils, care must be taken to ensure they are properly packaged within the endoleak nidus. Finally, plugs can safely and effectively occlude the target vessel right at the ostium, preserving any anastomosis that remains patent.

Although generally safe, secondary interventions for type II endoleak are often unsatisfactory because persistence/recurrence are commonly encountered. Therefore, follow-up imaging is key to evaluate technical and clinical success. Type II endoleak persistence/recurrence may be difficult to identify in the presence of Onyx™ or coils, because both cause significant scatter artifact on CT angiography. However, sac diameter measurements are usually not inhibited by the artifact and, when combined with duplex ultrasound and/or CEUS, recurrent flow within the sac can still be estimated with reasonable certainty.

CONCLUSION

Treatment of type II endoleak can be performed safely and effectively utilizing several approaches. When a transarterial route is performed, appropriate utilization of a support system into the SMA or internal iliac artery is recommended, followed by use of a microcatheter and a steerable microwire. Treatment is usually accomplished with a combination of plugs, coils, and/or Onyx™. Continued imaging follow-up after type II endoleak treatment is required to identify persistence/recurrence as well as stabilization or regression of the aneurysm sac.


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**Case Report**

Embozene™ Microspheres for Uterine AVM Embolization

By Juan Francisco Morales-Leon, MD; Robert J. Raymond, MD; Mary Brookes Ezell, MD; Bruce Bordlee, MD; and James Caridi, MD, FSIR

A 27-year-old woman who was gravida 3 para 2 presented to an obstetrics and gynecology clinic with complaints of persistent pelvic pain and vaginal bleeding following medical termination of pregnancy with methotrexate (without dilation and curettage [D&C]) about 4 weeks earlier. Physical exam at that time was notable for a 12-week–sized markedly tender uterus. Pelvic ultrasound revealed a large, hypervascular uterus with a large uterine arteriovenous malformation (AVM) measuring at least 3.5 cm X 1 cm in the sagittal plane (Figure 1).

The patient had a past medical history significant for systemic lupus erythematosus, arthritis, genital herpes, and cervicitis. Her most recent prior pelvic ultrasound was unremarkable (about 2 months prior to presentation). The AVM malformation was confirmed with a pelvic CTA, which also demonstrated dilated vessels within the endometrium raising the concern of retained products of conception (Figure 2). Because the patient desired future fertility, she was referred to the interventional radiology department for a possible uterine AVM embolization.

**Procedure**

The embolization was performed as an outpatient procedure, utilizing a right groin access that was achieved under direct ultrasound guidance. A 4-F Omni™ Flush catheter (AngioDynamics) was advanced through a 5-F Pinnacle® introducer sheath (Terumo Interventional Systems) into the distal abdominal aorta, with subsequent aortoiliac angiography demonstrating patent vessels with filling of a large uterine AVM, predominantly supplied by the left uterine artery without evidence of feeders from the right uterine artery (B).

Figure 1. Sagittal ultrasound of the uterus showed a 3.5-cm X 1-cm uterine AVM at the time of initial presentation.

Figure 2. Pelvic CTA showing axial, coronal, and sagittal views of approximately 5-cm X 5-cm X 1.5-cm dilated disorganized vascular structures encompassing the anterior and lateral uterine walls and fundus.

Figure 3. Arterial (A) and venous (B) phase frontal aortoiliac angiogram demonstrated filling of a large uterine AVM, supplied by the left uterine artery without evidence of feeders from the right uterine artery (B).
the left uterine artery (Figure 3). The catheter was then manipulated into the left hypogastric artery (Figure 4). Subsequently, a straight 0.021-inch 130-cm Renegade® STC-18 Microcatheter (Boston Scientific Corporation) was then advanced into the distal left uterine artery over a Fathom®-16 Guidewire (Boston Scientific Corporation). Additional images were obtained (Figure 5) before delivering four vials of 700-μm Embozene™ Microspheres (Boston Scientific Corporation). Due to a small amount of residual flow to the AVM, a gelfoam slurry was then used for further embolization, after which, near stasis was achieved with no filling of the AVM (Figure 6).

Interrogation of the right internal iliac artery was also performed and demonstrated no feeding vessels to the AVM. Because the patient desired future fertility and no flow to the malformation was identified, the decision was made to stop the procedure at this point.

RESULTS

Approximately 3 hours after the procedure, the patient began experiencing profuse vaginal bleeding followed by tachycardia and hypotension. The patient was sent for emergent repeat angiography (Figure 7). Because the right side was not embolized, the repeat bleeding was thought to come from that source, but was negative. Left uterine artery evaluation also revealed no radiographic evidence of bleeding. Ovarian artery interrogation was also negative. Products of conception were of primary concern after reviewing the imaging. An emergent D&C was then performed, revealing remaining products of conception as the source. Bleeding ceased following the procedure. The patient stabilized and the rest of her hospital course was unremarkable aside from mild pelvic pain. A 3-month follow-up pelvic ultrasound revealed complete resolution of the uterine AVM with a normal-appearing uterus and endometrium (Figure 8).
DISCUSSION

Uterine AVMs are almost always acquired and rarely congenital. They are typically seen in premenopausal women, and risk factors include multiple gestations, D&C, intrauterine devices, cesarean section, and infection. Uterine AVMs result from failed development of a primitive capillary plexus resulting in multiple intra- and extrauterine feeding arteries and large draining veins with an intervening vascular nidus. Acquired uterine AVMs result from abnormal communications between the intramural arterial branches and the myometrial venous plexus without an intervening vascular nidus. Acquired uterine AVMs are typically easier to treat with transarterial embolization due to a lack of extrauterine arterial supply with only one or both uterine arteries supplying one or two feeding vessels.

Uterine AVMs have the potential for life-threatening vaginal bleeding, mandating early diagnosis and treatment. It is important to note that treatment for uterine bleeding with D&C is contraindicated in the setting of a uterine AVM, as it can paradoxically worsen the bleeding. Depending on the severity of symptoms, uterine AVM treatment options range from watchful waiting and medical management to endovascular or surgical intervention. If asymptomatic, monitoring is preferred; spontaneous resolution is common. If symptoms are minimal, medical treatment with oral contraceptives or danazol is a potential option, with the reasoning that decreased blood flow to the uterus may permit the AVM to thrombose. For stable to unstable patients with acute to subacute bleeding, the patient’s desire for future fertility must be considered when determining surgical versus endovascular intervention. During instances of acute massive bleeding that require emergent intervention or if future fertility is no longer desired, hysterectomy should be considered as a definitive option. Catheter-directed uterine artery embolization is preferred when future fertility is desired.

When performing uterine AVM embolization, angiography of bilateral uterine arteries must be performed to evaluate for cross filling of feeder vessels. Furthermore, cross filling may not be apparent on initial angiography. Embolization can be performed with gelfoam, polyvinyl alcohol particles, microspheres, or glue. Complications of uterine artery embolization include pelvic pain, perianal skin sloughing, uterovaginal or rectovaginal fistulas, and lower extremity neurologic deficits. Retained products of conception can potentially result in profuse postprocedural bleeding under the guise of a failed intervention. Following a negative repeat angiogram, retained products of conception should be reconsidered as the source, especially in the setting of recent pregnancy.
A 72-year-old man had a metastatic neuroendocrine tumor to the liver that had undergone radioembolization 2 years prior; he presented with an enlarging 4-cm solitary lesion in Couinaud segment 5 visible on recent 3-month follow-up surveillance MRI. Of note, the patient had a prior history of surgery with ligation of the common hepatic artery origin. A history and physical examination was performed without evidence of encephalopathy or abdominal ascites. The patient’s performance status assessment indicated an Eastern Cooperative Oncology Group (ECOG) score of 0. Laboratory studies revealed unremarkable liver function tests, total bilirubin of 0.6 mg/dL, and albumin level of 4.2 g/dL. The coagulation profile and platelet levels were unremarkable. MRI demonstrated multiple lesions throughout the noncirrhotic liver with an enlarging solitary lesion in segment 5 (Figure 1). The patient was reviewed in a multidisciplinary neuroendocrine conference, and it was decided to proceed with embolization using 40-μm Embozene™ Microspheres (Boston Scientific Corporation) for palliative treatment of oligometastatic disease.

**PROCEDURE**

Angiography was performed to identify the tumor vascular supply and determine the optimal route for delivery of embolic materials. Through radial access, initial superior mesenteric angiography was performed, which identified a reconstitution of the right hepatic artery (RHA) arising through the pancreatic-duodenal arcade (Figure 2). Catheterization of the celiac artery was performed and reconstitution of the RHA arising from the right gastric artery was demonstrated (Figure 3). The RHA and segmental branch artery were selectively catheterized with a 2.4-F Direxion™ Microcatheter (Boston Scientific Corporation) over a Fathom™-16 Guidewire (Boston Scientific Corporation) (Figure 4). Embolization was performed with 40-μm Embozene™ Microspheres.
Microspheres until stasis was achieved. Confirmation postembolization angiography as well as cone-beam CT were performed (Figure 5).

A 4-week postprocedure liver MRI demonstrated 100% complete response (Figure 6). Follow-up laboratory studies were unremarkable and without treatment toxicity.

DISCUSSION
Catheterization and navigation through collateral vessels with microcatheter and wire manipulation may be challenging due to difficulty in selection and tracking of the microcatheter. As demonstrated in this case, the shapeable tip of the Fathom™-16 Guidewire and stable support in combination with the trackability of the Direxion™ Microcatheter allowed ease of catheterization of a RHA through the left and right gastric arteries despite surgical ligation of the common hepatic artery. Further subselection of segment 5 of the RHA was possible from radial access without an issue with length despite multiple turns. Tightly calibrated 40-μm Embozene™ Microspheres allowed distal embolization of the target tumor vessels with complete response on follow-up MRI.

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Disclosures: None.
A 61-year-old man with an otherwise unremarkable medical history presented to orthopedic surgery for chronic left shoulder pain, sequelae of a remote left shoulder trauma from a fall. He was planned for left shoulder arthroplasty. Routine preoperative clearance workup revealed incidental thrombocytopenia (platelet count was 47,000/μL). Due to this finding, the planned left shoulder surgery was deferred pending a comprehensive workup for the etiology of the isolated thrombocytopenia.

Further workup revealed an aspartate aminotransferase (AST) level of 53 U/L (normal range, 0-39 U/L), a normal alanine aminotransferase (ALT) of 40 U/L, alkanine phosphatase (ALP) level of 90 U/L, total bilirubin of 1.3 mg/dL, negative hepatitis serology, normal renal function, alpha-fetoprotein (AFP) level of 8.9 μg/L, carcinoembryonic antigen (CEA) of 7.4 μg/L, and a mildly elevated iron panel. CT imaging of the abdomen demonstrated splenomegaly with perisplenic and gastroesophageal varices. Multiple liver lesions were also found on CT.

A follow-up MRI of the abdomen confirmed a 4.9-cm segment 6 mass classified as LR-M, a 2.3-cm segment 6 LI-RADS 5 lesion, and a 2-cm segment 8 LI-RADS 3 lesion. The MRI also confirmed the previous CT findings of splenomegaly with perisplenic and gastroesophageal varices. The patient had no family history of liver disease. Social history was significant for alcohol use.

Due to the LR-M classification of the dominant segment 6 mass, he underwent a percutaneous CT-guided liver biopsy that confirmed histologically a well-differentiated hepatocellular carcinoma (HCC) (Figure 1).

The patient’s working diagnosis was multifocal HCC in the setting of Child-Pugh class A cirrhosis with a MELD score of 9. Preliminary assessment was intermediate (BCLC stage B) HCC. He was active, working, and fully functional (ECOG 0).

The multidisciplinary liver tumor board consensus was a recommendation for locoregional therapy, with the goal of tumor destruction to prevent disease progression with the potential for downstaging and consideration of liver transplant in the future. The options of bland embolization, chemoembolization, and radioembolization combined with thermal ablation were discussed with the patient, and he agreed with the recommendation for transarterial bland embolization (TAE) followed by microwave ablation of the segment 6 and segment 8 lesions.

PROCEDURE

The patient’s procedure was essentially uncomplicated with standard left radial access technique after a Barbeau test per protocol. A 5-F, 125-cm radial artery catheter was used to select the celiac trunk (Figure 2). After the celiac axis was selected, a 3-F Renegade® HI-FLO™ Microcatheter (Boston Scientific Corporation) was advanced into the right hepatic artery and on to the target lesions in segment 6 (Figure 3). The arteries were embolized to occlusion with a mix of ethiodol (to facilitate ablation targeting) and 100-μm Embozene™ Microspheres (Boston Scientific Corporation) (Figure 4).

The patient returned 1 month later for the planned thermal ablation of the aforementioned tumors. This procedure was performed under general anesthesia using CT fluoroscopy and 3D-reconstructed images for an oblique approach for the LeVeen CoAccess™ Electrode System (Boston Scientific Corporation) (Figure 5).

Follow-up MRI 6 months after ablation categorized the treated lesions as LR-TR nonviable (treated, probably or definitely not viable), consistent with successful treatment of
multifocal HCC by combination of bland TAE and thermal ablation (Figure 6). At 1-year follow-up, with no new findings, the patient was considered downstaged and is currently listed for transplant.

**DISCUSSION**

The indications for TAE in this presented patient’s case were unresectable HCC outside the Milan criteria for liver transplant with intermediate BCLC stage B disease, and the possibility of downstaging to resection or transplant criteria. With a fully functional performance status and no evidence of hematological dysfunction, encephalopathy, or other clinical findings suggesting poorly compensated advanced liver dysfunction, the patient was an excellent candidate for TAE.

HCC is a significant cause of morbidity and mortality in patients with liver cirrhosis. Transarterial chemoembolization (TACE) is currently recommended as the standard of care in patients with unresectable HCC by the National Comprehensive Cancer Network and the American Association for the Study of Liver Diseases. Both TACE and bland TAE without the delivery of chemotherapeutic agents are based on hepatic physiology and anatomy. While the hepatic parenchyma receives most of its blood supply from the portal vein, neoplastic hepatocytes receive their blood supply principally from the hepatic artery due to tumor-associated angiogenesis and neoangiacty. Therefore, the embolization of the hepatic artery branches preferentially impacts tumor cells over normal hepatocytes. Randomized controlled trials have demonstrated the superiority of TACE over best supportive care and the equivalence of bland embolization with TACE.

The combination of ablation with embolization appears to extend the efficacy of ablation for larger (>3 cm) tumors.

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Gonadal Vein Embolization for Pelvic Congestion Syndrome

BY DAVID FELDSTEIN, MD

A 68-year-old woman presented with persistent pelvic pain and pressure predominantly on the left side that she had experienced for several years. The symptoms were exacerbated upon prolonged standing, and would improve after lying down and in the morning hours. There was no reported postmenopausal bleeding. Her symptoms were consistent with pelvic congestion syndrome. Treatment options included conservative hormonal therapy (eg, medroxyprogesterone), hysterectomy with oophorectomy, and gonadal vein embolization. After discussing the efficacy of the provided treatment options, the patient decided to proceed with gonadal vein embolization.

PROCEDURE

Embolization was performed via a right transfemoral vein approach. The left renal vein was selected utilizing a 5-F cobra catheter. Digital subtraction venography demonstrated significant reflux throughout a dilated left gonadal vein (Figure 1). Multiple distended collaterals were visualized draining across midline into the right hemipelvis. Delayed imaging also revealed collateral drainage into the left internal iliac vein. A Renegade® STC-18 Microcatheter (Boston Scientific Corporation) with a Fathom™-16 Steerable Guidewire (Boston Scientific Corporation) were advanced through the 5-F base catheter into the distal gonadal vein. Embolization of the left gonadal vein and associated tributaries was then performed using multiple Interlock™-18 Fibered IDC Coils (Boston Scientific Corporation) ranging in diameters of 10 to 12 mm. Coils were placed within 3 to 5 cm of the left gonadal/renal vein confluence. Postembolization venography demonstrated successful occlusion of the left gonadal vein and its tributaries/collaterals (Figure 2).

RESULTS

At 2-week follow-up, the patient demonstrated significant improvement in pelvic pain/pressure. There were no reported access site complications. If symptoms recur, the likelihood of right gonadal vein embolization was discussed. Right gonadal vein embolization was not performed at the time of initial therapeutic intervention, due to predominantly left-sided symptoms.

DISCUSSION

The 0.018-inch coil delivery system is preferred for this procedure, as it allows for preferential selection of the distal gonadal vein branches, as well as the smaller tributaries/collaterals. Literature suggests that lack of embolization of these tributaries/collaterals can lead to clinical failure and/or recurrence.

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Disclosures: None.
Direxion and Direxion Hi-Flo

CAUTION: Federal law restricts this device to sale by or on the order of a physician. Rx only. Prior to use, please see the complete "Directions for Use" for more information on Indications, Contraindications, Warnings, Precautions, Adverse Events, and Operator’s Instructions.

INTENDED USE/INDICATIONS FOR USE

The Direxion and Direxion Hi-FLO Torqueable Microcatheters are intended for peripheral vascular use. The pre-loaded Fatmorn and Transend Guidewires can be used to selectively introduce and position the microcatheter in the peripheral vasculature. The microcatheter can be used for controlled and selective infusion of diagnostic, embolic, or therapeutic materials into the vessel.

CONTRAINDICATIONS

None known.

WARNINGS

- Never advance or withdraw an intravascular device against resistance until the cause of resistance is determined by fluoroscopy. Movement of the microcatheter or guidewire against resistance may result in damage or separation of the microcatheter or guidewire tip, or vessel perforation.
- This Direxion Microcatheter family is not intended for use in the coronary vasculature or neurovasculature.
- The Direxion Hi-FLO Microcatheter is not designed for the delivery of embolic coils.
- Use of excessive force to manipulate the microcatheter against resistance can cause a fracture in the nitinol shaft. Take care not to over-torque the microcatheter in order to relieve any tension before withdrawal by rotating the microcatheter in the opposite direction.

PRECAUTIONS

- This device should be used only by physicians thoroughly trained in percutaneous, intravascular techniques and procedures.
- Do not introduce the microcatheter without guidewire support as this may cause damage to the proximal shaft of the catheter.
- Because the microcatheter may be advanced into narrow sub-selective vasculature, repeatedly assure that the microcatheter has not been advanced so far as to interfere with its removal.

ADVERSE EVENTS

The Adverse Events include, but are not limited to:

- Allergic reaction
- Death
- Embolism
- Hemorrhage/
Hematoma
- Vessel spasm
- Vessel trauma
- Vascular thrombosis
- perforation, rupture)

Embozene Microspheres

CAUTION: Federal law restricts this device to sale by or on the order of a physician. Rx only. Prior to use, please see the complete "Directions for Use" for more information on Indications, Contraindications, Warnings, Precautions, Adverse Events, and Operator’s Instructions.

INTENDED USE/INDICATIONS FOR USE

Embozene Microspheres are intended for the embolization of arteriovenous malformations and hypervascular tumors, including uterine fibroids (UFE) and hepatoma, and for embolization of prostatic arteries (PAE) for symptomatic benign prostatic hyperplasia (BPH). The device is not intended for neurovascular use.

MAGNETIC RESONANCE IMAGING

Embozene Microspheres are MR safe.

CONTRAINDICATIONS

Embolization procedures shall not be performed if:
- Patient is unable to tolerate vascular occlusion procedures.
- Vascular anatomy precludes correct catheter placement or embolic injection.
- Presence or likely onset of vasospasm.
- Presence of a blood coagulation disorder that would prohibit arterial punctures.
- Presence of severe atheromatous disease that would preclude correct catheter placement.
- Presence of patient extra-to-intra-cranial anastomoses or shunts from the arterial to the venous circulation.
- Presence of collateral vessel pathways which could potentially endanger non-targeted tissue during an embolization procedure.
- Presence of any vasculature where Embozene Microspheres could pass directly into the central nervous system, central circulatory system or other non-target territories.
- Patient has high-flow arteriovenous shunt with diameter greater than the selected Embozene Microspheres.
- Patient is pregnant.
- Patient has known allergies to barium sulfate, 3-aminopropyltrialkoxysilane, polyphosphazene or IV radiopaque contrast agent.

CONTRAINDICATIONS SPECIFIC TO UFE

In addition to the general embolization contraindications, uterine fibroid embolization procedures shall not be performed if:
- Presence of suspected or active pelvic inflammatory disease.
- Presence of malignancy of the pelvic region.
- Presence of endometrial neoplasia or hyperplasia.
- Presence of submucosal fibroids with more than 50% growth into the uterine cavity.
- Presence of pedunculated serosal fibroid as the dominant fibroid(s).
- Presence of fibroids with significant collateral feeding by vessels other than the uterine arteries.

CONTRAINDICATIONS SPECIFIC TO PAE

In addition to the general embolization contraindications, Prostatic Artery Embolization (PAE) procedures for benign prostatic hyperplasia shall not be performed if:
- Evidence of prostatic cancer or bladder cancer
- Urethral stricture.
- Prostate size (less than) 40 grams.
- Active prostatitis.
- Interest in the preservation of fertility.
- Peak urinary flow rate (greater than) 12 ml/sec.
- Large bladder diverticula or stones.
- Neurogenic bladder.
- Detrusor failure.

WARNINGS

- Vascular embolization is a high risk procedure. The procedure should be performed by specialized physicians trained in vascular embolization procedures.
- Care must be taken to choose larger sized Embozene Microspheres when embolizing arteriovenous malformations with large shunts to avoid passage of the microspheres into the venous and subsequently to the pulmonary circulation.
- Extreme caution should be used for any procedures above the neck, and risk benefit assessment should be performed to avoid non-target embolization complications.
- Risks of radiation from angiography and fluoroscopy used to visualize the blood vessels during embolization, which may include a radiation burn and risks to future fertility.
- Do not use Embozene Microspheres in conjunction with embolization devices based on organic solvents such as ethyl alcohol or dimethyl sulfoxide (DMSO) at the same embolization site.
- Do not use ionic contrast agent with this product. Ionic contrast agents could alter the microsphere characteristics resulting in microsphere deformation and procedure failure.
- Do not use heparinized saline as this could lead to microsphere agglomeration. Agglomeration may impede microsphere delivery through the catheter or result in non-target embolization.
- Should catheter obstruction occur, remove the catheter from the patient. Do not use forceful injection, guidewires or other instruments to dislodge the blockage.

WARNINGS SPECIFIC TO UFE

- Do not use microspheres smaller than 50 μm.
- The diagnosis of uterine sarcoma could be delayed by taking a nonsurgical approach (such as UFE) to treating fibroids. It is important to pay close attention to warning signs for sarcoma (e.g., rapid tumor growth, postmenopausal with new uterine enlargement, MRI findings) and to conduct a more thorough work-up of such patients prior to recommending UFE. Recurrent or continued tumor growth following UFE should be considered a potential warning sign for sarcoma and surgery should be considered.

WARNINGS SPECIFIC TO UFE AND PREGNANCY

There is no long-term data on the effects of UFE on the ability to become pregnant and carry a fetus to term, and on the development of the fetus. This procedure should only be performed on women who do not intend future pregnancy. Women who become pregnant following UFE may be at increased risk for the following:
- Postpartum hemorrhage
- Abnormal placentation
- Preterm delivery
- Devascularization
- Caesarean delivery
- of the uterus
- Malpresentation
- myometrium
- resulting from

WARNINGS SPECIFIC TO PAE

- An appropriate urological work-up should be performed on all patients (e.g., urological history and appropriate testing, such as Prostate-Specific Antigen test and, when appropriate, biopsy to rule out carcinoma).
- The efficacy of prostatic embolization on male fertility has not been determined. Therefore, this procedure should only be performed on men who are willing to accept the risk of future infertility.
- Three-dimensional planning imaging (e.g., magnetic resonance angiography (MRA), computed tomographic angiography (CTA) should be performed prior to embolization on patients who have had any previous invasive treatment to the prostate (e.g., surgery, ablation, etc.) or pelvic irradiation.
POTENTIAL ADVERSE EVENTS SPECIFIC TO UFE:

- Uterine/Ovarian necrosis
- Diarrhea
- Hematuria/ Hematomas
- Retch Bleeding
- Rectal or lower colonic strictures
- Sexual dysfunction or impaired fertility
- Urinary tract burning sensation
- Urinary tract infection
- Urinary symptoms (e.g. dysuria, urgency, frequency)

ADVERSE EVENTS

- Vessel trauma
- Vessel damage
- Embolism (cathereter/ device, air bubble, plaque, thrombus, air embolism, thromboembolism)
- None known.

CAUTION: Federal law (USA) restricts this device to sale by or on the order of a physician. Rx only. Prior to use, please see the complete “Directions for Use” for more information on Indications, Contraindications, Warnings, Precautions, Adverse Events, and Operator’s Instructions.

INTENDED USE/INDICATIONS FOR USE

The LeVeen Needle Electrode Family is intended to be used in conjunction with the RF 3000 Generator for the thermal coagulation necrosis of soft tissues, including partial or complete ablation of nonresectable liver lesions. These procedures should only be performed by physicians and staff familiar with the equipment and techniques involved.

PRECAUTION

Before using, inspect the package for any breach to the sterile barrier and inspect product for any damage. If package is broken or product is damaged DO NOT USE. Immediately return package and product to Boston Scientific.
WARNINGS
• The colored insulated cannula must be used at all times when accessing tissue. Use of the electrode without the colored insulated cannula may result in serious burns to the patient and/or user.
• Damage to the insulation of the introducer may result in serious burns to the patient and/or user.
• Precaution: The LeVeen Needle Electrode Family must be used in conjunction with the Boston Scientific RF 3000™ Generator.
• For patients with permanent pacemakers and Implantable Cardiac Defibrillators (ICD) additional precautions should be taken.

ADVERSE EVENTS
The complications that may result from a peripheral embolization procedure include, but are not limited to:

• Abscess
• ARDS (Acute Respiratory Distress Syndrome)
• Arrhythmia
• Ascites
• Biloma
• Burn
• Death
• Delayed hemorrhage into ablated tissue
• Diarrhea
• Electric Shock
• Hematoma
• Hemorrhage
• Insufficiency
• Infection
• Liver Insufficiency
• Perforation
• Persistent Fever
• Pleural Effusion
• Tumor Recurrence
• Tumor Seeding

90960743 Rev/Ver. AB

Renegade HI-FLO Microcatheter

CAUTION: Federal law (USA) restricts this device to sale by or on the order of a physician. Rx only. Prior to use, please see the complete “Directions for Use” for more information on Indications, Contraindications, Warnings, Precautions, Adverse Events, and Operator’s Instructions.

INTENDED USE/INDICATIONS FOR USE
The Renegade HI-FLO Microcatheter is intended for peripheral vascular use. The microcatheter can be coaxially tracked over a steerable guidewire in order to access distal, tortuous vasculature. Once the subselective region has been accessed, the microcatheter can be used for the controlled and selective infusion of diagnostic, embolic, or therapeutic materials into vessels. Diagnostic, embolic, or therapeutic agents to be used in accordance with specifications outlined by the manufacturer.

CONTRAINDICATIONS
None Known.

WARNINGS
The Renegade Microcatheter and Microcatheter Kit are not intended for use in the coronary vasculature or the neurovasculature.

PRECAUTIONS
• This device should be used only by physicians thoroughly trained in percutaneous, intravascular techniques and procedures.
• Never advance or withdraw an intravascular device against resistance until the cause of the resistance is determined by fluoroscopy. Movement of the microcatheter or guidewire against resistance may result in separation of the microcatheter or guidewire tip, damage to the microcatheter or guidewire tip, or vessel perforation.
• Because the microcatheter may be advanced into narrow subselective vasculature, repeatedly assure that the microcatheter has not been advanced so far as to interfere with its removal.

ADVERSE EVENTS
The Adverse Events include, but are not limited to:

• Vessel trauma
• Hemorrhage/
• Embolism
• Hematoma
• Vasospasm
• Infection
• Air embolism
• Allergic reaction

90960755 Rev/Ver. AB

Renegade STC 18 Microcatheter

CAUTION: Federal law (USA) restricts this device to sale by or on the order of a physician. Rx only. Prior to use, please see the complete “Directions for Use” for more information on Indications, Contraindications, Warnings, Precautions, Adverse Events, and Operator’s Instructions.

INTENDED USE/INDICATIONS FOR USE
The Renegade STC 18 Microcatheter is intended for peripheral vascular use. The microcatheter can be coaxially tracked over a steerable guidewire in order to access distal, tortuous vasculature. Once the subselective region has been accessed, the microcatheter can be used for the controlled and selective infusion of diagnostic, embolic, or therapeutic materials into vessels. Diagnostic, embolic, therapeutic agents to be used in accordance with specifications outlined by the manufacturer.

CONTRAINDICATIONS
None Known.

WARNINGS
The Renegade STC 18 Microcatheter is not intended for use in the coronary vasculature or the neurovasculature.

PRECAUTIONS
• This device should be used only by physicians thoroughly trained in percutaneous, intravascular techniques and procedures.
• Never advance or withdraw an intravascular device against resistance until the cause of the resistance is determined by fluoroscopy. Movement of the microcatheter or guidewire against resistance may result in separation of the microcatheter or guidewire tip, damage to the microcatheter or guidewire tip, or vessel perforation.
• Because the microcatheter may be advanced into narrow subselective vasculature, repeatedly assure that the microcatheter has not been advanced so far as to interfere with its removal.

ADVERSE EVENTS
The Adverse Events include, but are not limited to:

• Vessel trauma
• Hemorrhage/
• Embolism
• Hematoma
• Vasospasm
• Infection
• Air embolism
• Allergic reaction

90960758 Rev/Ver. AB

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