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LINC 2016

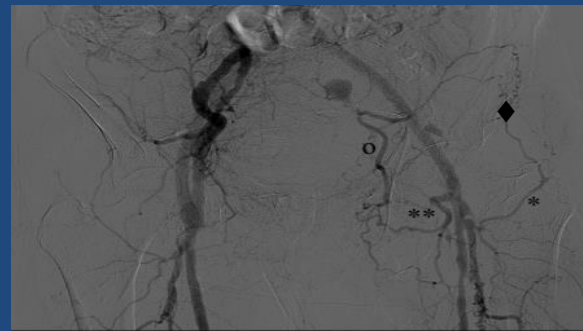
**Introduction:** After surgical or endovascular aortic aneurysm repair a persistent preexisting internal iliac aneurysm may continue to grow leading to a challenging solution once there is no direct aneurysm access.

## PAST MEDICAL HISTORY:

- ♂, 77 Y
- Abdominal aortic aneurysm (AA A) 5.5 cm Ø, Internal Iliac Aneurysm (IIA) 6,4 cm Ø
- 2012 Aortobifem surgical bypass (ABF), proximal and distal ligation (external iliac artery)
- 18 months later: abdominal pain+ haematuria+ hypotension + ↓ 2 g Hb**



**Pic 1.** Angio-CT : IIA 10,0 cm Ø, not excluding rupture.

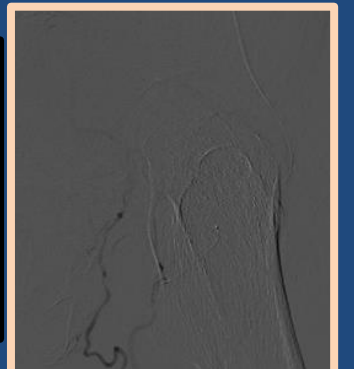


**Pic 2.** Initial angio showing contrast leakage in the IIA and it's dependence collateral chains:  
- A. medial femoral circumflex (MCFA\*\*) with obturator (o) artery.  
- Lateral femoral circumflex (LFCA\*) with sup gluteal (♦).

## MATERIAL AND METHODS:

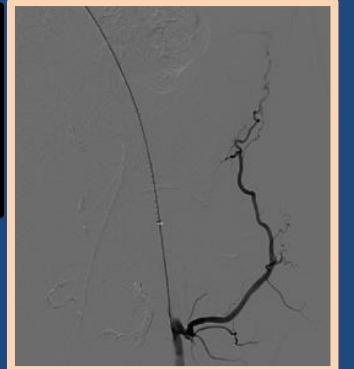
### **Pic 3.** 1st procedure:

- Left brachial access.
- Selective catheterization of the profunda femoral artery + Supraselective MCFA catheterization (microcatheter 1.5 F);
- Onyx® embolization



### **Pic 4.** 2nd procedure:

- Femoral contra-lateral access
- Onyx was injected after MP crossover of ABFB trough microcatheter of LCFA.



## RESULTS:

**Pic 5.** Patient underwent successful embolization of both arteries close to aneurysm sac. Completion angiography didn't show any apparent residual endoleak. Shrinkage 8.6 cm Ø at 6th month follow up



**Discussion/Conclusion:** IIAs may grow and rupture after exclusion, leading to challenging decision and treatment. Multiple collateral pathways between the femoral and the internal iliac artery can be embolized with a wide range of materials. This is a feasible technique, with minimal surgical aggression and low complication rate with few cases reported in literature.