

Coiling a Type II Endoleak With a 2-RO, 155-cm Direxion™ Microcatheter

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CASE DESCRIPTION AND DISCUSSION

A patient presented with a type II endoleak with a long and tortuous feeding vessel, which we believed to be the inferior mesenteric artery (Figures 1 and 2). After we initially gained access with a SIM1 diagnostic catheter and advanced more distally with a 0.021-inch (0.53-mm), preshaped, 2-RO-tip Direxion™ Microcatheter, we ran out of length because the 100-cm SIM1 catheter would not allow us to reach the target. We switched out the entire system, using only a 300-cm-long, 0.014-inch (0.36-mm) Fathom® Guidewire. The Fathom®-14 Guidewire provided plenty of support for the exchange, and we did not need to open an additional device such as a long sheath. We advanced a longer, 4-F (1.33-mm) nontapered, angled diagnostic catheter into the inferior mesenteric artery and then reinserted a 155-cm Direxion™ Microcatheter, one of the longest microcatheters on the market. We needed every last centimeter of the 155-cm length, as we used the Direxion™-Fathom® combination to access the target endoleak site and prepare for coil embolization (Figure 3).

We deployed six Interlock™-18 Coils precisely into the aneurysm sac, with help from the two radiopaque markers on the Direxion™ Microcatheter, and left the last coil to trail out into the feeding vessel as an anchor (Figures 4 and 5). To keep cost in mind, we finished the embolization with a few small VortX® Diamond 0.018-inch (0.46-mm) pushable coils to finish packing the coil nest.

The flow to the endoleak site drastically diminished (Figures 6–8), and we feel strongly that the Dacron® (Invista) fibers on the Interlock™-18 Coils will continue to thrombose and create a complete occlusion. ■

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Figure 1



Figure 2



Figure 3

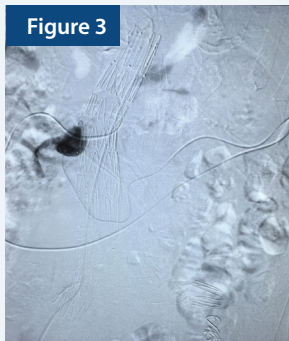


Figure 4



Figure 5

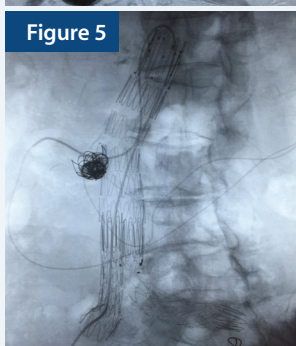


Figure 6

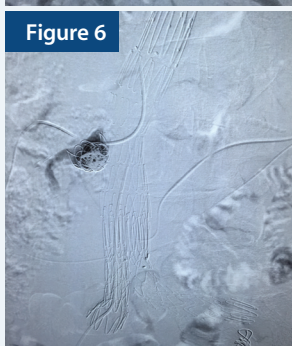


Figure 7

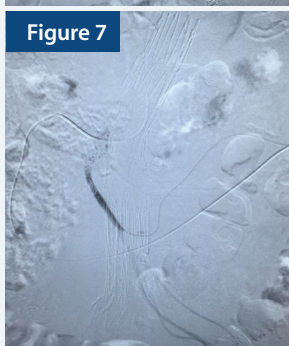


Figure 8

