

CASE REPORT

Coiling a Type II Endoleak

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A 76-year-old woman with a history of endovascular aortic aneurysm repair was monitored for an enlarging aneurysm sac and a type II endoleak.

Because of the location of the previously placed stent graft and the endoleak (Figure 1), an endovascular approach via the left internal iliac artery was selected. Using a 5-F, 0.038-inch inner diameter selective diagnos-

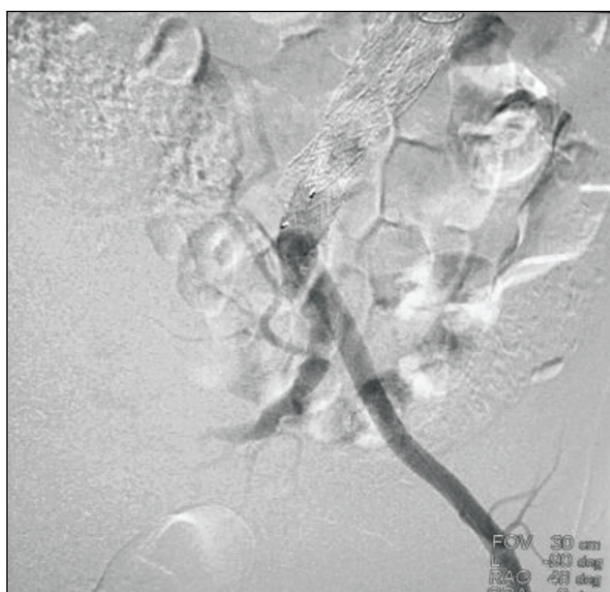


Figure 1. The previously placed stent graft and endoleak.



Figure 2. The origin of the left ilio-lumbar artery.

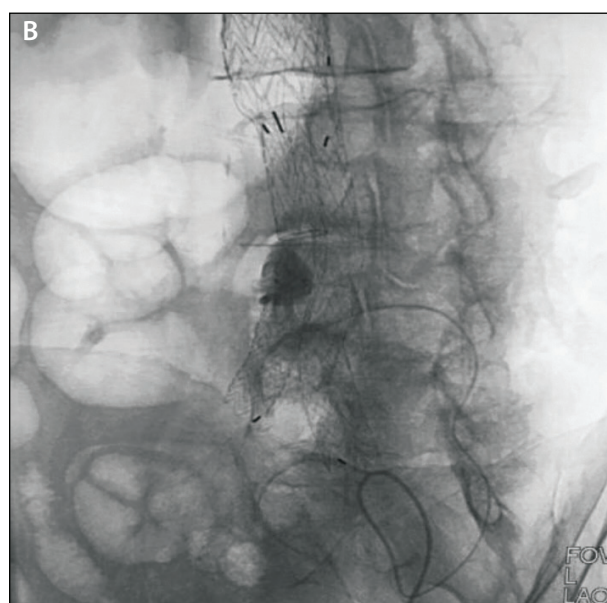
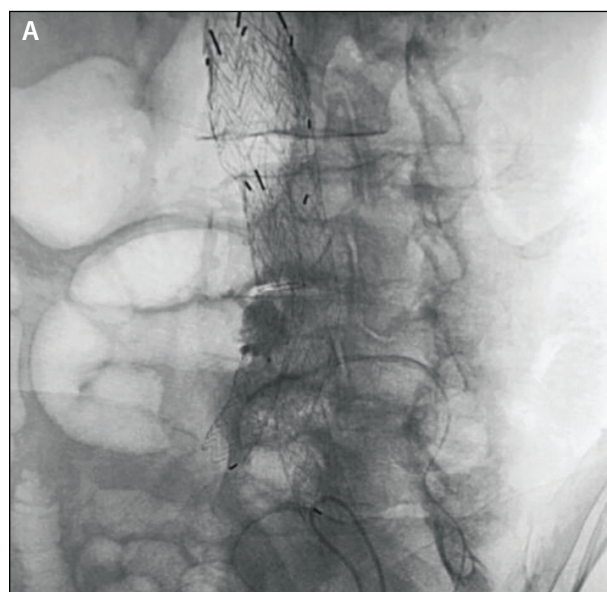


Figure 3. A large aneurysmal void was identified as the cause of the endoleak.



Figure 4. The sac and the feeding vasculature were embolized.

tic catheter, the origin of the left iliolumbar artery was identified with a contrast injection (Figure 2). Because of the small diameter and the significant tortuosity of the origin of the iliolumbar artery, the 5-F catheter was advanced only slightly beyond the origin of the vessel.

An 0.021-inch inner lumen diameter Direxion™ J-shaped Microcatheter (Boston Scientific Corporation) and a torqueable 0.016-inch Angled Fathom®-16 Steerable Guidewire (Boston Scientific Corporation) were passed through the diagnostic catheter into the iliolumbar artery. After significant catheter and wire manipulation through the anastomosis with the left lumbar artery, access to the sac was achieved, and a contrast injection revealed a large aneurysmal void that was causing the endoleak (Figures 3A and 3B). After positioning the microcatheter within the aneurysm and

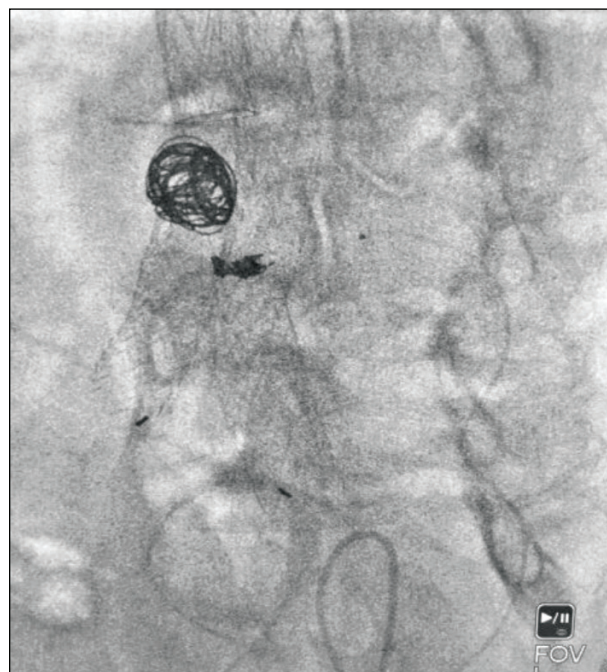


Figure 5. Using six coils, occlusion of the type II endoleak was achieved.

removing the guidewire, the process of embolizing both the sac and the feeding vasculature began (Figure 4).

The embolization procedure was completed using a number of Interlock™-18 Fibered Platinum Coils (Boston Scientific Corporation), each with a wide diameter and a long length to ensure adequate wall apposition. Using a total of six coils, 210 cm of coil were rapidly deployed in both the endoleak channel and feeding vessel, and occlusion of the type II endoleak was achieved (Figure 5). ■

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Disclosures: None.