

Uterine Artery Embolization Supported by *syngo* iFlow

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W. Rilling, M.D., at his lab in the vascular and interventional radiology division.

Patient history

42-year-old female with an 18 month history of increasing menorrhagia and pelvic fullness. She preferred to avoid hysterectomy. The patient was self referred to the IR clinic to discuss UFE as a treatment option. After discussing the risks, benefits, and alternatives, the patient chose to proceed with UFE.

Diagnosis

Symptomatic uterine fibroids

Treatment

Bilateral uterine artery embolization was performed via a right common femoral artery approach. The uterine arteries were selected with a high flow microcatheter under roadmapping guid-

ance and embolization performed with 500-700 micron tris-acryl gelatin spheres. The patient was observed overnight for pain control and was discharged the following morning. *syngo* iFlow post-processing was performed on the DSA images.

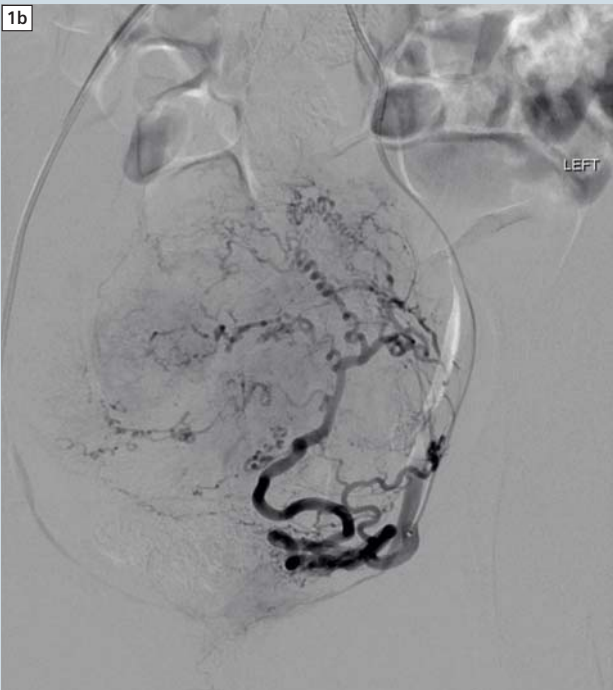
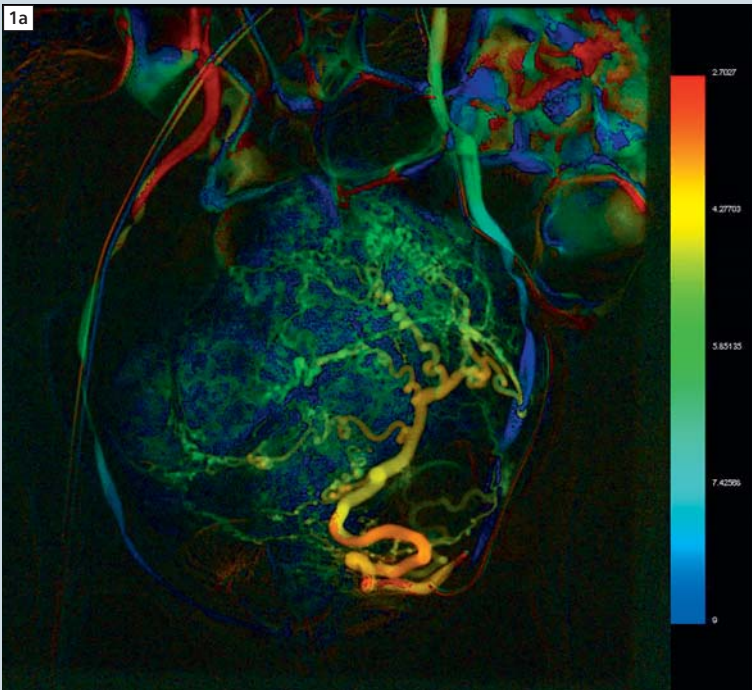
Comments

There has been considerable debate in the literature regarding the desired embolization endpoint for UFE. Differences in technique including embolization agent and embolization endpoint clearly determine patient outcome. Quantifying and reproducing embolization endpoints are difficult using current DSA technology.

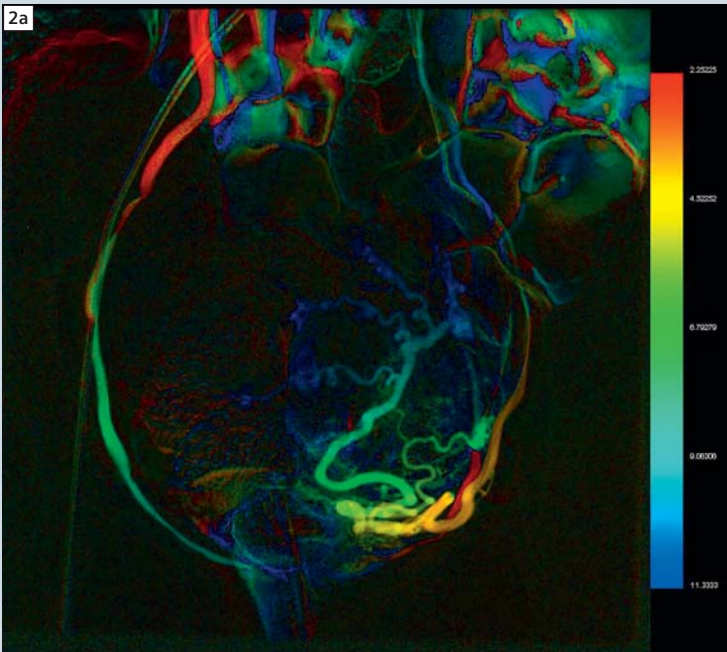
Using *syngo* iFlow, the blood flow can be quantified to potentially allow for objective endpoint determination and comparisons between patients, operators, and embolic materials. *syngo* iFlow provides the ability to quantify the outcome of the embolization. For instance, in this case, time to peak value in the uterine artery has been slowed by almost 5 seconds compared to the pre-embolization image. This is information that we could not extract from the standard DSA run.

Contact

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1 (a+b) Left uterine artery pre-embolization syngo iFlow and DSA images.



2 (a+b) Post-embolization syngo iFlow and DSA images.