

# Outside Your IO Comfort Zone: Learning from Our Saves and Complications

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# Disclosures

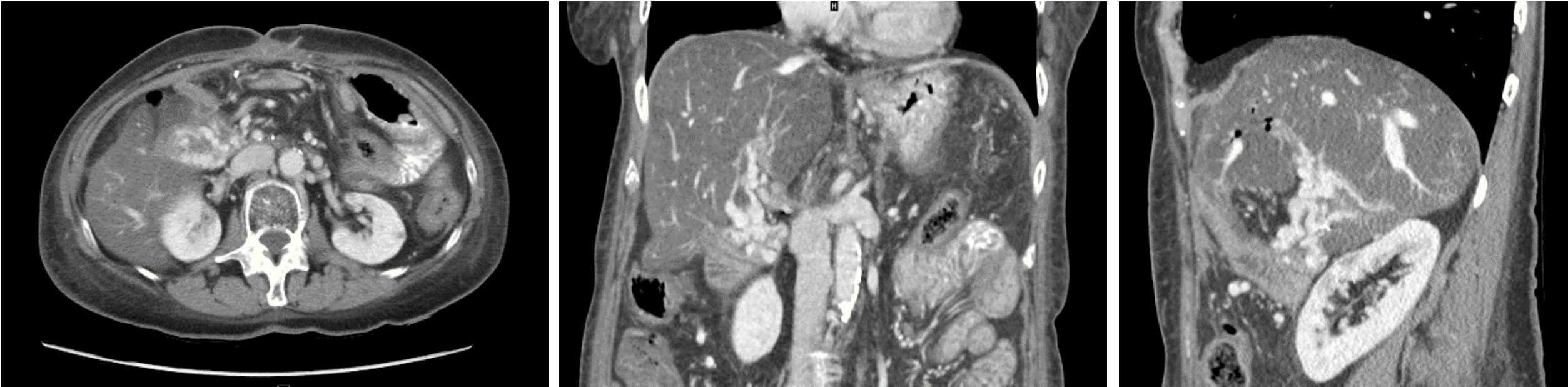
- NOTHING TO DISCLOSE

# CASE 1

70-year-old female with Hx of:

- Pancreatic adenoca s/p Whipple procedure in 2014
- Metachronous pancreatic tail ca in 2018 s/p distal pancreatectomy and splenectomy in Aug 2018
- Patient developed recurrent episodes of LGIB requiring multiple admissions and blood transfusions
- Multiphase CT angiography:
  - Whipple anatomy with surgically absent splenic vein.
  - Occlusion of the Celiac axis and common hepatic artery
  - Chronic main portal vein occlusion (> 3 years) with cavernous transformation fed by multiple intramural varices/portal hypertensive enteropathy: Varices within the wall of the afferent limb arising from branches of the superior mesenteric vein supplying the cavernoma

# CASE 1

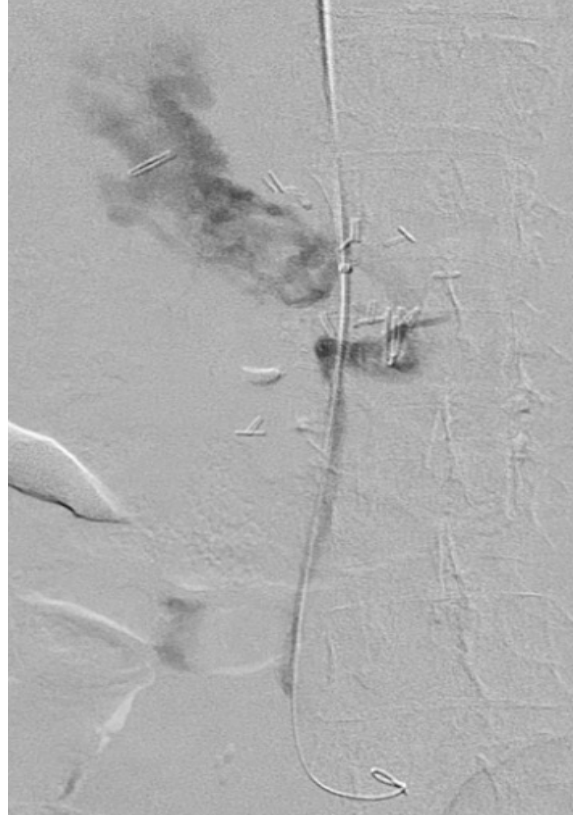


CT: chronic main portal vein occlusion with cavernous transformation fed by multiple intramural varices arising from the patient's afferent limb following pancreaticoduodenectomy.

# CASE 1

- Several failed endoscopic interventions: no endoscopic options
- No surgical options
- Percutaneous trans-hepatic recanalization of the PV to SMV attempted at OSH: unsuccessful
- Options discussed (including attendings at different institutions)
  - Sclerotherapy of the afferent limb varices (direct injection/via SMV)
  - TIPS to the cavernoma
  - Mesocaval shunt
  - Nothing: maintain the patient with blood transfusions. Patient refused this option

# CASE 1



Venography: multiple serpiginous varices within the wall of the afferent limb at the liver hilum. The portal vein is not visualized due to chronic occlusion.

# CASE 1



Mesocaval shunt placement: brisk flow across the conduit with non-opacification of afferent limb varices.

# CASE 1

- Post-procedure day seven: Encephalopathy refractory to aggressive medical management
- Mesocaval shunt reduction. Gradient pre: 5 mmHg was measured across the shunt. Technique: “sheath control” and inserted a 8 mm x 59 mm balloon mounted covered stent was deployed with its mid portion constrained. Gradient post: 11 mm Hg. Venography demonstrated partial reconstitution of mesenteric venous collaterals



Patient's encephalopathy improved but she developed progressive liver insufficiency and passed away 2 months after the shunt placement due to hepato-renal Sd.

# Case 2

- 70 year-old male with esophageal cancer
- Status post esophagectomy/partial gastrectomy
- Chronic aspiration
- Jejunostomy tube requested for enteric nutrition

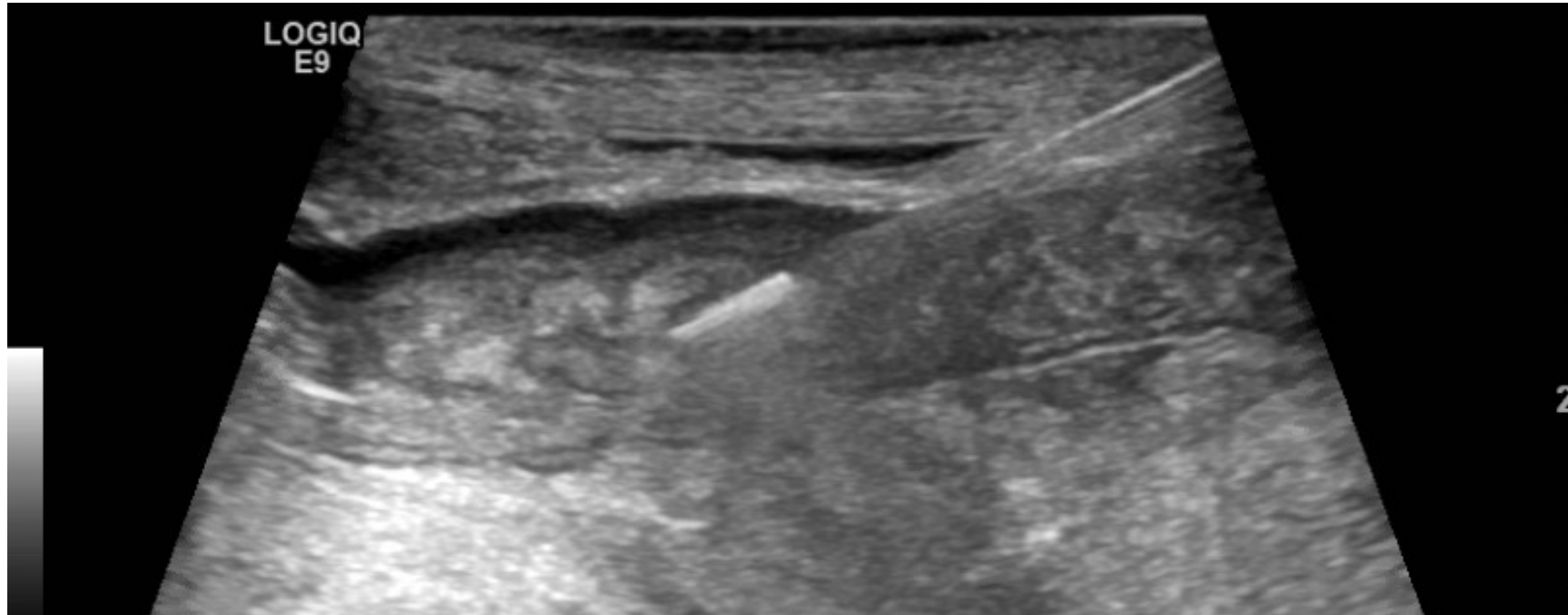
# Case 2

## Difficult Patient Anatomy



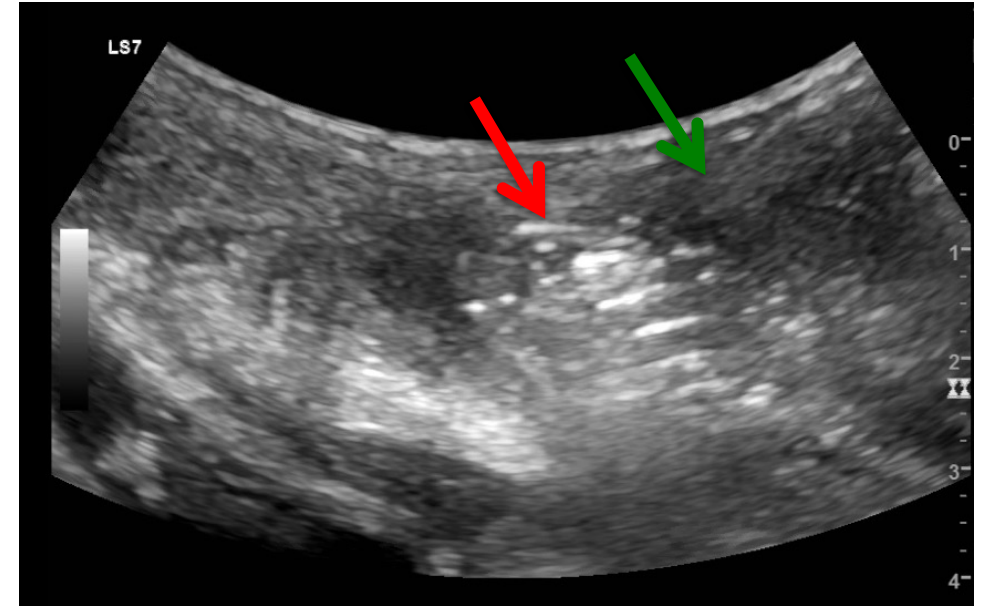
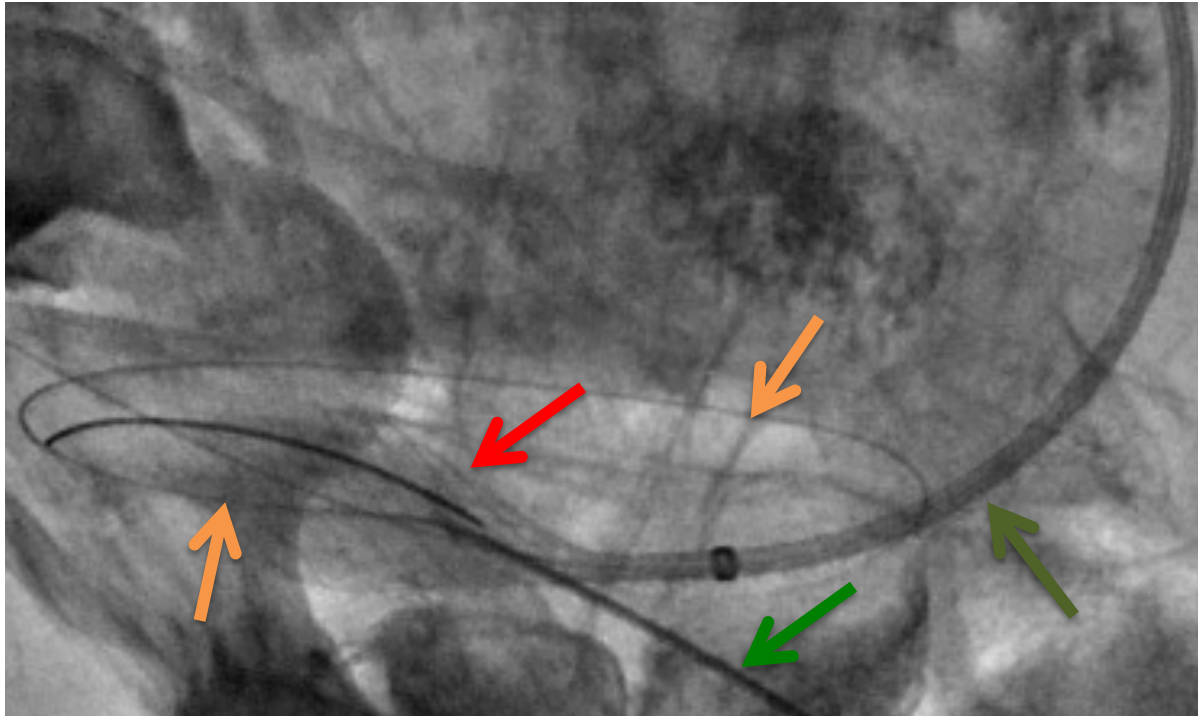
“Axial” cut through the chest

# Initial US-guided J-tube Attempt



- **Multiple attempts with 21/22g needle failed (two attendings)**
- **Tented and pushed away by needle**
- **Made more difficult by ascites**

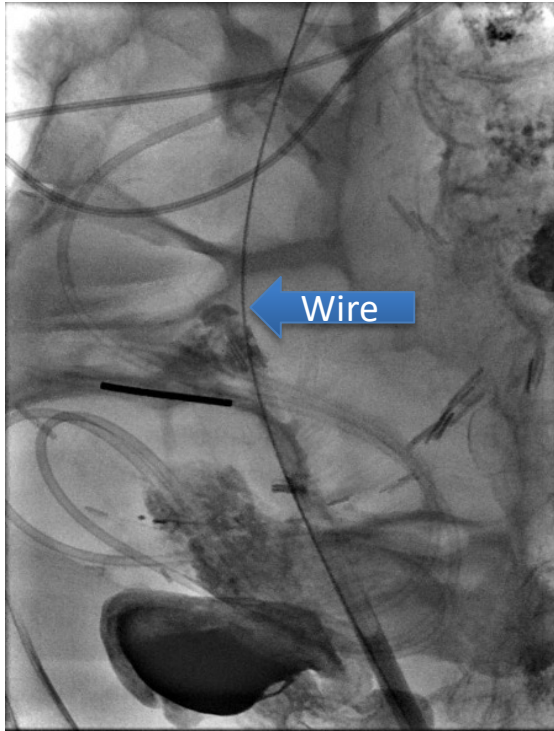
# Case 2: Stent-Assisted J-tube Placement



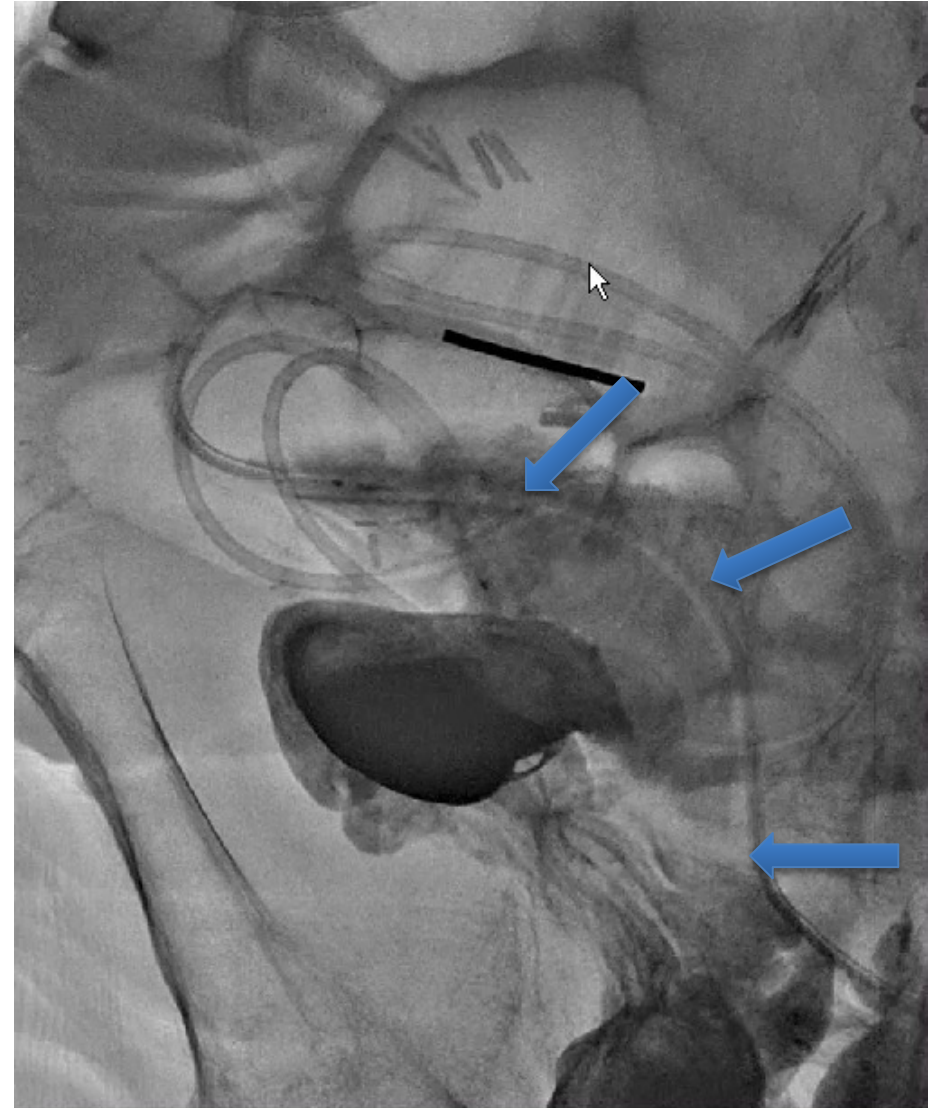
- Partial deployment of 22mm x 120mm Wall Stent in the jejunum (trans-nasal access)
- 19g needle puncture through interstices and Jagwire placed
- Stent recaptured and pulled out through nose with wire
  - Through and through wire access

- Stent
- Access Needle
- Stent Sheath
- Access Wire

# Case 2: Stent-Assisted J-tube Placement



- 5 Fr dilator advanced over Jagwire
- Exchange made for Amplatz
- Serial dilatation and placement of 14 Fr J-tube over wire
- Position confirmed with contrast injection



# Outside of your IO comfort zone...

- Making decisions and managing expectations: Can be really hard!!!
  - Mesocaval shunt was chosen as the possible lowest risk alternative?. Wrong choice?
  - Patient physician relationship is a critical component: trust and vulnerability. Patient knew that it was the first time we tried this procedure at our institution
- You have to be ready to fail. Failure is part of the process as long as you get something out of the experience (Fail=First Attempt in Learning). When you learn you are expanding the size of your comfort zone.
- Challenging yourself pushes you to unlock untapped knowledge

# Outside of your IO comfort zone...

- Trying new things can make you more creative but at the cost of increase our vulnerability and possible rejection
- Embracing new challenges can help you age better: comfort zones tend to shrink as we get older
  - Impact on others, particularly juniors, to stimulate them and solve “real life problems”
- Don't push to hard and find the level of optimal anxiety to improve your performance.
- Discuss these cases with your colleagues and find you IR soul mates: develop a “collective responsibility”. May be difficult to find partners in your institution to take on challenges