

This leaflet tells you about having embolisation of a vascular mass. It explains what is involved and what the possible risks are. It is not meant to replace informed discussion between you and your doctor, but can act as a starting point for such discussions. If you have any questions about the procedure please ask the doctor who has referred you or the department which is going to perform it.

What is embolisation?

An embolisation is the term used to describe the blocking of blood vessels. When an abnormal mass is present in the body that contains a lot of blood vessels, embolisation can be used to reduce the blood supply.

Why do you need embolisation?

Your doctors know that there is an abnormal mass present and will have discussed all the possible treatment options. Embolisation is one such option that can be used either before surgery to reduce the blood supply to the abnormal mass to ensure a safer operation or as a primary treatment to stop bleeding and reduce the size of the mass. This can be used in both benign and cancer masses. Examples include fibroid embolisation, high flow vascular malformations and cancer embolisation (often from the kidney or thyroid). Embolisation will not have any effect on any other further treatments that may be necessary such as chemotherapy or radiotherapy.

Are there any risks?

Embolisation is a very safe procedure, but as with any medical procedure there are some risks and complications that can arise. Occasionally a small bruise may develop in your groin at the needle-entry site. Most patients feel some pain afterwards, which ranges from very mild to very severe pain. It is generally worst in the first 12 hours and can be controlled by painkillers.

Embolisation will cause some swelling of the mass initially. If the mass is in the spine or pelvis, embolisation may increase the symptoms you currently have. These typically are short lived and often disappear following surgery. There is, however, a small risk that loss of sensation or power may be permanent.

There is also a rare risk of non-target embolisation (embolisation of vessels not supplying the mass or tumour). The initial angiogram will determine the safety for embolisation; however, if it does occur it is generally not a significant problem. This does depend slightly on where the tumour or mass is situated; the interventional radiologist doing the procedure will explain the slight differences to you.

Who has made the decision?

The consultant in charge of your care and the interventional radiologist performing the procedure have discussed your case and feel that this is the best option. However, you will also have the opportunity for your opinion to be considered and if, after discussion with your doctors, you no longer want the procedure, you can decide against it.

Are you required to make any special preparations?

You will be an inpatient in the hospital. You may be asked not to eat for four hours before the procedure, although you may still drink clear fluids such as water.

If you have any allergies or have previously had a reaction to the dye (contrast agent), you *must* tell the radiology staff before you have the test.

Who will you see?

A specially trained team led by an interventional radiologist within the radiology department. Interventional radiologists have special expertise in reading the images and using imaging to guide catheters and wires to aid diagnosis and treatment.

Where will the procedure take place?

In the angiography suite or theatre; this is usually located within the radiology department. This is similar to an operating theatre into which specialised X-ray equipment has been installed.

What happens during embolisation?

You will be asked to get undressed and put on a hospital gown. A small cannula (thin tube) will be placed into a vein in your arm.

You will lie flat on your back. You may have monitoring devices attached to your chest and finger and may be given oxygen. Your groin will be swabbed with antiseptic and you will be covered with sterile drapes.

Local anaesthetic will be injected into the skin in your groin to numb the area. A

needle will be inserted into the artery followed by a fine plastic tube called a catheter.

The interventional radiologist uses X-ray equipment to guide the catheter towards the arteries that are feeding the vascular mass. A special X-ray dye (contrast agent) is injected into the catheter to ensure a safe position for embolisation. The contrast may give you a hot feeling in the pelvis. When the interventional radiologist is happy with the catheter position, the vascular mass is embolised. There are many different agents available for embolisation; the interventional radiologist will explain the differences before the procedure.

Once the interventional radiologist is satisfied with the images, the catheter will be removed. Firm pressure will be applied to the skin entry point, for about ten minutes, to prevent any bleeding. Sometimes a special device may be used to close the hole in the artery.

Will it hurt?

When the local anaesthetic is injected, it will sting for a short while, but this soon wears off. You may develop cramp-like pelvic pain toward the end of the procedure, but this can be treated with intravenous painkillers.

How long will it take?

Every patient is different, and it is not always easy to predict; however, expect to be in the radiology department for about two hours.

What happens afterwards?

You will be taken back to your ward. Nursing staff will carry out routine

observations including pulse and blood pressure and will also check the treatment site. You will stay in bed for at least six hours. You will be kept in hospital overnight and may be discharged the next day. If you are having surgery after embolisation, this will typically occur within 48 hours.

Finally

Some of your questions should have been answered by this leaflet, but remember that this is only a starting point for discussion about your treatment with the doctors looking after you. Make sure you are satisfied that you have received enough information about the procedure.

Contact:

British Society of Interventional Radiology
www.bsir.org

This leaflet has been prepared by the British Society of Interventional Radiology (BSIR) and the Clinical Radiology Patients' Liaison Group (CRPLG) of The Royal College of Radiologists. Approved by the Board of the Faculty of Clinical Radiology: 25 February 2011

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Radiology**

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Patient information

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The Royal College of Radiologists