endoscopic findings were analyzed against clinical outcomes including 30-day mortality, 30-day reintervention (including angiography, endoscopy, or surgery), and a composite outcome of 30-day mortality or reintervention.

**Results:** Among clinical and demographic factors analyzed, elevated INR, BUN, pre-embolization blood transfusion requirement, and decreased platelet counts were statistically significant predictors of all analyzed outcomes. Among analyze dendoscopic characteristics, number of ulcers was the only factor that was statistically significant predictor of 30-day reintervention. Neither Forrest classification nor isolated duodenal bulb location of the ulcers were found to be statistically significant predictors of our analyzed outcomes.

**Conclusions:** As previously described in the literature, clinical and demographic factors associated with primary hemostasis or coagulation were found to be statistically significant predictors of our outcomes. Number of duodenal ulcers on endoscopy was also a statistically significant predictor of 30-day reintervention.

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**Tibial-pedal artery access for uterine artery embolization**

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**Purpose:** To demonstrate the rationale for and feasibility of tibial-pedal (TP) access as an alternative to trans-radial (TR) or trans-femoral (TF) access for uterine artery embolization (UAE).

**Materials and Methods:** 9 women ages 33-62 (mean 44) with a mean BMI of 32 (range 22.8-48.4) underwent UAE via TP access by a single operator in an academic center. 6 women had symptomatic fibroids, 2 women had hemorrhage from invasive uterine or cervical cancer, and 1 woman had post-partum hemorrhage from an arteriovenous malformation. Patencies of tibio-pedal arteries were documented pre-procedurally with palpation and/or ultrasound. With ultrasound guidance and micropuncture technique, a 5 French Gihdesheath Slender (Terumo, USA) was placed and anti-spasmotic/anti-thrombotic medications were administered as previously reported for TR access. Hemostasis was achieved at embolization procedures’ end with a large TR band (Terumo, USA) reinforced with cloth tape. Proprietary catheters were used, though steam shaping of the base catheters was necessary for the initial cases. All 6 patients undergoing UAE for fibroids were discharged home the same day. Metrics evaluated were technical success, fluoroscopy time, clinical results and complications.

**Results:** 8 of 9 UAEs were successfully performed via TP access; one patient required cross over to TF access for ipsilateral uterine artery catheterization. No clinically significant procedural complication occurred. Average fluoroscopy time was 38.3 minutes, though the last four cases performed with a proprietary cobra shaped catheter led to reduction of average fluoroscopy usage to 23.4 minutes. All patients with fibroids had either unchanged or palliated symptoms at short-term follow-up, and impatients with acute bleeding were discharged shortly after the embolizations with cessation of hemorrhage. All patients expressed satisfaction with the vascular access, and access artery patency was objectively demonstrated from 5 hours post procedure to 6 weeks in clinic via either manual palpation or ultrasound in 6/8 patients; 2 patients chose not to return to clinic during COVID-19 pandemic but were asymptomatic at phone follow-up; access arterial pulse could not be palpated in 2 asymptomatic patients at clinic follow-up (ultrasound was unavailable).

**Conclusions:** The advantages of TP access mirror that of TR access, with few and mostly minor complications, and the risk of iatrogenic cerebral embolization is nil. Tibio-pedal arteries are a feasible alternative access for uterine artery embolization.

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**The effect of non-alcoholic steatohepatitis on mortality, estimated cost, and length of stay after elective and non-elective transjugular intrahepatic portosystemic shunt**

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**Purpose:** To evaluate the effect of non-alcoholic steatohepatitis (NASH) on mortality, cost, and length of stay after elective and non-elective transjugular intrahepatic portosystemic shunt (TIPS) placement.

**Materials and Methods:** The 2017 National Inpatient Sample (NIS) from the Healthcare Utilization Project (HCUP), Agency for Healthcare Research and Quality was used to identify patients admitted for TIPS using International Classification of Diseases Tenth Revision (ICD-10) procedure codes (06183J4 and 06184J4).