packing. Five weeks post partum, the patient presented with recurrent unprovoked bleed. Ultrasound and Magnetic Resonance Angiography (MRA) were demonstrated retained placental tissue with dilated vessels and increased vascular flowconsistent with retained placenta accreta and vascular malformation. First session embolisation was performed using Embospheres particles 700-900 microns (Merit Medical Inc., USA). A second embolisation procedure was carried out via the left CFA using micro coils (Boston Scientific, Watertown, MA, USA) and gelfoam pledges until complete occlusion was achieved. Two months post-partum, the patient presented complaining of foul smelling vaginal discharge, due to necrotic placenta and received full course of antibiotics with dilatation and curettage. Follow-up US demonstrated no residual vascular malformation. **Conclusions:** Placenta accreta and uterine AVMs are recognised causes of uterine bleeding. Uterine artery embolization is an alternative treatment for uncontrolled postpartum haemorrhage and an effective treatment for acquired AVM's outside of pregnancy.

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Staged Percutaneous Ultrasound Guided Bleomycin Sclerotherapy Could be a Promising First Line of Treatment for Orbital Lymphatic Malformations in Children

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Background: Orbital lymphatic malformations are benign vascular lesions that can be challenging to treat. Although a conservative approach is preferred in small lesion, larger ones may cause amblyopia if treatment is delayed. Surgical debulking is difficult with an associated risk of haemorrhage or collateral damage. We aim to evaluate the effectiveness and safety of ultrasonographic and fluoroscopic guided intra-lesional Bleomycin injection sclerotherapy in cases of orbital lymphatic malformations in children. **Methods:** In this prospective study, 4 children diagnosed with unilateral orbital lymphatic malformations (from June 2015-February 2016) were subjected to repeated percutaneous ultrasound and flouroscopic guided Bleomycin injections (2000-2500 iu each) after accurate assessment of extent, size and cystic architecture by Magnetic Resonance Imaging (MRI). All children presented with disfiguring proptosis with or without subconjunctival or eyelid extension of the lesion. MRI was repeated after 2 months of injection for radiological assessment. **Results:** An acceptable clinical improvement of proptosis as well as a diminution in more than 50% of the volume of the lesion by MRI and replacement of the bright signal by low signal ill defined area with the disappearance of cysts was achieved in all subjects after an average of 3 to 6 injections (2 months interval). Except for a transient painful oedema of the periorbital tissue for few days after injection, no major complications were noted. Follow up 8-15 months. **Conclusions:** Intralesional Bleomycin therapy could be a safe and effective first choice treatment for children with orbital lymphatic malformations.

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Safety Assessment of Continuous Versus Discontinuous Warfarin Therapy in Cardiovascular Endovascular Procedures: Observations from a Meta-analysis

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Background: Endovascular procedures are commonly performed in patients with a history of anticoagulation treatment. Proper balance between reduction of thromboembolic events and the risk of bleeding is necessary to improve perioperative patient outcomes. Anticoagulation achieved with oral medication is not easily reversible, thus many patients are advised to discontinue warfarin and are given heparin before endovascular procedure. An alternative strategy, to perform endovascular procedures in patients without interruption of anticoagulation therapy, has been adopted. In our study we conducted a meta-analysis of complication rates and outcomes in patients undergoing endovascular procedures who receive continuous versus discontinuous warfarin therapy. **Methods:** Literature published between 2000 and 2015 was searched for reports of comparative studies of vascular procedures. Information on periprocedural complications and patient deaths less than 30 days after the procedure was extracted. A random effects model was used and odds ratios (ORs) were reported. An OR of less than 1 was considered to indicate lower risk of the outcome with discontinuous warfarin therapy. Meta-analysis was conducted by using meta-analysis software. **Results:** A total of 32 studies of 15,326 patients were included. For arterial procedures, there were no significant differences between the continuous versus discontinuous warfarin therapy groups in access site hematoma (OR, 0.59; 95% confidence interval [CI]: 0.33, 1.03; P =0.06), any bleeding complications (OR, 0.56; 95% CI: 0.30, 1.06; P =0.07), mortality (OR, 1.40; 95% CI: 0.37, 5.25; P =.62), intracranial hemorrhage (OR, 0.55; 95% CI: 0.03, 8.91; P =.68), ischemic stroke (OR, 0.85; 95% CI: 0.12, 5.84; P =.87), and major bleeding (OR, 0.56; 95% CI: 0.21, 1.51; P =.25). For venous procedures, uninterrupted warfarin was associated with lower odds of access site hematoma (OR, 0.70; 95% CI: 0.50, 0.99; P =.04), any bleeding complications (OR, 0.61; 95% CI: 0.48, 0.77; P <.01), ischemic stroke (OR, 0.21; 95% CI: 0.10, 0.45; P <.01), and major bleeding (OR, 0.64; 95% CI: 0.51, 0.80; P <.01). For arterial and venous procedures combined, uninterrupted warfarin was associated with lower odds of access site hematoma (OR, 0.68; 95% CI: 0.51, 0.91; P =.01), bleeding complications (OR, 0.59; 95% CI: 0.48, 0.74; P <.01), ischemic stroke (OR, 0.25; 95% CI: 0.12, 0.50; P <.01), and major bleeding (OR, 0.61; 95% CI: 0.49, 0.77; P <.01). Heterogeneity in most analyses was low, and confidence in the estimates was moderate. **Conclusions:** Continuous perioperative warfarin therapy is safe for patients undergoing arterial procedures, but discontinuous warfarin may be preferred for those undergoing venous procedures; no differences in outcome rates were found in the randomized controlled trials. Future studies are required to confirm these results.