utilizing suction aspiration devices (Penumbra®, Alameda, CA). Total cost to patient for each case was calculated. Mean cost and standard deviation was calculated for each technique and compared using Student's t-test.

**Results** The total product cost to the patient for interventional management of vascular occlusions in a selected group of patients is given in the table.

**Abstract E-045 Table 1**

| Suction aspiration | | Stent retriever | |
|---|---|---|---|
| **Vessel** | **Cost (US Dollars)** | **Vessel** | **Cost (US Dollars)** |
| Left M1 | 29567.74 | Left M1 | 57969.07 |
| Left M1 | 72196.56 | Left M1 | 57939.89 |
| Right M1 | 30653.12 | Right M1 | 63189.56 |
| Right M1 | 69704.34 | Right M1 | 64366.48 |
| Right M1 | 29668.39 | Right M1 | 58068.76 |
| **Mean** | 46358.03 | **Mean** | 60071.37 |
| **Standard Deviation** | 22470.99 | **Standard Deviation** | 2846.91 |
| **P-value** | 0.14 | | |

**Conclusion** A cursory evaluation of the data from this selected subset of patients suggests that there may be no significant difference in overall product cost to the patient for utilization of these two techniques for performance of mechanical thrombectomy. However, upon closer inspection of the data, the cost for aspiration thrombectomy appears to vary quite widely across the subset, with a standard deviation of $22470.99, while the standard deviation for stent retrieval is $2846.91. It is difficult to determine whether this trend would be borne out in a larger sample set; however, it may suggest that product utilization in aspiration thrombectomy may vary considerably among operators and in varying situations while product utilization in stent retrieval thrombectomy may be more constant. Further exploration of this trend with larger patient subsets is warranted.

**Disclosures P. Brown:** None. **M. Cobb:** None. **T. Smith:** None. **A. Zomorodi:** None. **L. Gonzalez:** None.

## E-046 PROCEDURAL EFFICIENCY OF THE STREAMLINED LAUNCHPAD STROKE ADMISSION PARADIGM – A SINGLE CENTER EXPERIENCE

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**Introduction** Time remains a crucial factor in stroke progression. Rapid and complete revascularization has been well correlated with favorable clinical outcome in patients with acute ischemic stroke secondary to large vessel occlusion. To mitigate the deleterious effects due to treatment delay, an initiative has been implemented to shorten the time for patient processing, expediting LVO patients for immediate intervention. The Launchpad protocol was established to ensure admitting stroke patients are triaged quickly and accurately identified in order to reduce time from arrival to intervention, and overall to revascularization. Herein, we assess the efficacy of the Launchpad paradigm in triaging presenting stroke patients.

**Methods** A retrospective review of the stroke database was conducted between September 2014 and January 2016, 3 months prior and 13 months post Launchpad implementation. Prior to Launchpad, patients presenting with stroke were triaged through the traditional Emergency Department (ED) pathway. Through Launchpad, incoming patients bypass the traditional ED pathway and are taken straight for a CT scan by a dedicated stroke team. A CT scan positive for LVO and penumbral tissues will permit patients to continue through the Launchpad pathway for further evaluation and subsequent intervention. Time differences during patient triage before and after Launchpad initiation are assessed to determine the efficiency of this paradigm.

**Results** In total, 764 patients were identified in the retrospective analysis, 137 were admitted prior, and 627 were admitted post Launchpad implementation. In the pre-Launchpad cohort, the median time from admission to CT imaging was 20 minutes. Patients under the Launchpad paradigm showed a reduction in time from presentation to imaging of 5 minutes ($p = 0.0004$). An increase in efficiency by roughly 25% to CT was observed following Launchpad implementation.

**Conclusion** The streamlined stroke activation Launchpad protocol demonstrated an increased speed in patient admission and significant reduction in time from presentation to CT scan. This significant improvement in processing time allowed for an increased number of patients to meet the therapeutic window for IV tPA eligibility. A prospective trial will strengthen the current finding and support the implementation of this paradigm amongst other stroke centers.

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## E-047 DISTAL EMBOLI FOLLOWING ERIC THROMBECTOMY

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**Introduction** The use of clot retrievers during mechanical endovascular treatment of acute ischemic stroke can cause clot fragmentation with the release of distal emboli. It was our hypothesis that the risk of embolic shower may potentially be altered using the Embolus Retriever with Interlinked Cages (ERIC®) thrombectomy system. The objective of this study was the characterization of distal emboli generated during ERIC® thrombectomy device use as a function of access approach.

**Materials and methods** A hard, inelastic clot was prepared and injected into an anatomically correct circle of Willis (CoW) replica to form a middle cerebral artery occlusion. Thrombectomy was conducted per the manufacturer's instructions in four different groups (n = 10), each exploring different variables. In group 1, thrombectomy was performed using the ERIC® through an 8 F balloon guide catheter (BGC) positioned at the cervical ICA (ERIC®+BGC). In group 2, thrombectomy was performed using the ERIC® in conjunction with thromboaspiration via a 6 F Sofia intermediate catheter at the origin of the MCA (ERIC®+SOFIA). In group 3, thrombectomy was performed using the Solitaire in conjunction with thromboaspiration via a 6 F Sofia intermediate catheter at the origin of the MCA (Solitaire+SOFIA). Group 4 used the same setup as group 2 with the addition of proximal ICA flow arrest using a BGC during clot removal (ERIC®+SOFIA