presence of DCI are both associated with increased mRS at 90 days.

Conclusions Use of ASA does not appear to confer worse outcomes in cerebral aneurysm rupture and subarachnoid hemorrhage.

Disclosures V. Patel: None. F. Al Mufti: None. R. Gupta: None.

E-148 DECOMPRESSIVE CRANIECTOMY IN ACUTE STROKE PATIENTS IN KOREAN SINGLE CENTER

K Jang*, B Cho, B Moon, K Kim, D Jang. *Neurosurgery, Incheon St. Mary's hospital, The Catholic University of Korea, Bupyeong-gu, Incheon, Korea, republic of*

10.1136/neurintsurg-2019-SNIS.223

Introduction Decompressive craniectomy (DC) is a life-saving surgical procedure being increasingly employed for malignant intracerebral artery stroke. The purpose of this study is to investigate the characteristics and prognostic factors of patients undergoing DC after acute ischemic stroke.

Method From 2013 to 2018, we analyzed the prospective gathered data of 58 consecutive patients treated with DC after acute ischemic stroke in a single center. Also, we analyzed the prospective gathered data of 160 consecutive patients treated with mechanical thrombectomy using stent-retrievers for acute ischemic stroke in a single center. Demographic, clinical, laboratory, and radiologic features of each patient were investigated. We compared the characteristics of patients who underwent DC with those of patients who received medical treatment.

Results Of the total 3884 acute ischemic stroke patients, 58 patients(1.49%) were underwent DC. Of 289 patients who underwent mechanical thrombectomy due to acute ischemic stroke, DC was performed in 32 patients(11.07%). Of the patients who underwent mechanical thrombectomy due to acute ischemic stroke, post thrombectomy complications (100% vs 22.81%, $p=0.000$), preprocedural TICI grade ($p=0.001$) were significantly higher in patients who underwent DC compared to patients who did not receive craniectomy. 30 days mRS scores(5.13 vs 3.37, $p=0.000$), 90 days mRS scores(5.06 vs 3.17, $p=0.000$), ICU hospital days(21.53 vs 8.65, $p=0.000$) and hospital mortality(46.88% vs 12.5%, $p=0.000$) were significantly higher in the craniectomy patients.

Conclusions Patients who underwent DC had more post procedural complications, and the functional outcomes were worse after DC in acute ischemic stroke. However, since DC is the last treatment option for patients with severe cerebral infarction who are not responding to medical treatment, it is advisable to consider active management while managing the underlying disease and periprocedural complications.

Disclosures K. Jang: None. B. Cho: None. B. Moon: None. K. Kim: None. D. Jang: None.

Late-Breaking Oral Abstracts

1 THE RIVER TRIAL: A TRIAL OF VENOUS SINUS STENTING WITH THE RIVER STENT IN IDIOPATHIC INTRACRANIAL HYPERTENSION (IIH)

A Patsalides*. *Weill Cornell Medical College, New York, NY*

10.1136/neurintsurg-2019-SNIS.224

Introduction Venous sinus Stenting (VSS) is an emerging treatment for patients with IIH. However, VSS is currently performed with stents designed for stenting atherosclerotic arterial stenosis. The River™ stent has been specifically designed for treating the stenosis of the transverse-sigmoid sinuses and has the following characteristics: easy navigability through the tortuosity of the sigmoid sinus; 7 cm long length to cover the venous sinuses from the torcula to the mid sigmoid segment; two zones of radial force to address the intrinsic stenosis at the sigmoid transverse junction (stiffer zone) and extrinsic stenosis of the mid transverse sinus (softer zone); and large open cells to adapt to the triangular shape of the venous sinus without occluding cortical veins.

Methods The River trial is a single arm pivotal trial designed for HDE approval of the River™ stent (Serenity Medical Inc, Redwood City, CA). The trial will enroll 39 subjects in 7 clinical sites. Subjects must have proven IIH and >50% stenosis of the sigmoid-transverse sinus with pressure gradient ≥ 8 mm Hg. Subjects can be enrolled on visual criteria: visual field deficit from -6 db to -30 db resistant to medical therapy >2 weeks; or on headaches criteria: severe headaches defined by Headache Impact Test (HIT-6) >59 resistant to medical therapy >4 weeks. The patients need to be on dual antiplatelet therapy (aspirin and clopidogrel) for 3 months and aspirin monotherapy for 9 more months.

The primary safety endpoint is the rate of major adverse event (any neurological complication plus need for any surgical procedure for IIH) at 12 months. The primary efficacy endpoint is a composite at 12 months of clinical improvement and absence of significant venous stenosis. Secondary endpoints at 12 months include opening pressure on lumbar puncture, individual ophthalmology endpoints, change in pulsatile tinnitus, change in medications, change in quality of life scores.

Results Enrollment started in September 2018. Four sites are active at the time of submission of this abstract and three other sites are in the process of certification. Eleven subjects have been enrolled. In all 11 cases the catheterization with the River™ stent was extremely easy and the stent was deployed as expected. In two patients with severe stenosis from arachnoid granulation, post-stent angioplasty was performed. There was resolution of the trans-stenotic gradient in all cases. There was no stent-thrombosis. There was no impairment of flow in the cortical veins draining into the stented segment. There were no major neurological adverse events or device related complications.

None of the enrolled patients reached the 12-month follow-up time point and therefore we cannot report on primary