conducted to determine the association between baseline subject comorbidities, clot characteristics and reperfusion, with a focus on imaging findings. The plan for per pass analysis both by an independent core imaging laboratory and by an independent clot analysis laboratory sets apart this registry from other similar studies. In addition, the reperfusion assessment by the independent core lab will be using innovative eTICI.

Disclosures A. Siddiqui: 1; C; Co-investigator NIH/NINDS 1R01NS091075. 2; C; Amnis Therapeutics, Boston Scientific, Canon Medical Systems USA Inc, Cerebrotech Medical Systems, Cereonovus, Corindus Inc., EndoStream Medical Ltd, Guidepoint Global Consulting, Imperative Care, Integra LifeSciences Corp, Medtronic, MicroVention, Q’Apel Medical Inc, Rapid Medical, Rebound Therapeutics Corp., Serenity Medical Inc, Silk Road Medical, StimMed, Stryker, Three Rivers Medical, VasSol, W.L. Gore & Associates. 4; C; Amnis Therapeutics, Apama Medical, Blink TBI Inc, Buffalo Technology Partners Inc, Cardinal Consultants, Cerebrotech Medical Systems, Cognition Medical, EndoStream Medical Ltd, Imperative Care, International Medical Distribution Partners, Neurvascular Diagnostics Inc, Q’Apel Medical Inc, Rebound Therapeutics Corp, Rist Neurovascular In, Serenity Medical, Silk Road Medical, StimMed, Synchon, Three Rivers Medical Inc, Viseon Spine. T. Andersson: 2; C; Neuravi, Ablynx, Amnis Therapeutics, Medtronic, Rapid Medical, Stryker. S. De Meyer: None. K. Doyle: None. J. Fiehler: None. W. Hacke: None. R. Hanel: 2; C; Three Rivers Medical, Medtronic, MicroVention, Codman, Stryker, T. Jovin: 2; C; Neuravi, codman, Medtronic, Stryker, Silk Road, Anaconda, Blockade Medical. D. Kallmes: None. D. Liebeskind: None. A. Yoo: 2; C; Cerenovus. O. Zaidat: 2; C; Stryker, Medtronic, Neuravi, Penumbra. R. Nogueria: 2; C; Neuravi, Medtronic, Penumbra, Stryker.

Introduction Selective Posterior Cerebral Artery Amobarbital Test: A Predictor of Memory Following Subtemporal Selective Amygdalohippocampectomy


10.1136/neurintsurg-2019-SNIS.46

Background Mechanical thrombectomy (MT) is standard of care for treatment of acute ischemic stroke due to proximal anterior circulation large vessel occlusion, such as the M1 segment of the middle cerebral artery (MCA). The effectiveness and complication profile in more distal vessels such as the M2 segment, however, remains to be completely defined.

Methods All MT treatments for acute M1 or M2 occlusion between 2011 and 2018 were retrospectively reviewed. Patients with thrombectomy using Merci device, intra-arterial pharmacological thrombolysis, mechanical wire maceration, or only using a balloon were excluded. Patient characteristics (age, NIHSS), number of passages, first passage recanalization success (TICI 2b or higher), total recanalization success, and hemorrhagic complications (ICH and SAH) were compared between M1 and M2 groups.

Results Two hundred sixty cases, including 171 M1 and 89 M2 occlusions, were analyzed. The mean age of patients and median of NIHSS were 70.7 ± 15.0 (SD) years and 15 (1–33), respectively. There was no significant difference between M1 and M2 groups for age and NIHSS (p=0.727 and p = 0.065, respectively). The total number of passages in M2 group was significantly less than M1 group (Median of 1 and range of 1 to 5 versus median of 2 and range of 1 to 7, p=0.023). First passage recanalization success rate was significantly higher in the M2 group than the M1 group (55.1% versus 39.2%, p = 0.015). The total recanalization success rate also trended higher in the M2 group, but it did not reach statistical significance (83% versus 74.7%, p=0.132). Subarachnoid hemorrhage rate was significantly higher in the M2 group than the M1 group (24.7% versus 12.3%, p = 0.010), but there was no difference for ICH between the two groups (p = 0.862).

Conclusion Mechanical thrombectomy for M2 occlusions is effective, has a higher rate of first pass recanalization, and has...
shorter total pass number than M1 thrombectomy. However, mechanical thrombectomy in the M2 using recent generations of stent retriever technology is associated with higher rates of SAH, likely related to tension on the vessels when pulling through a more tortuous MCA segment.


**P-012** SHORTER DOOR-IN DOOR-OUT TIME IS ASSOCIATED WITH HIGHER LIKELIHOOD OF ENDOVASCULAR THERAPY AND GOOD OUTCOMES

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10.1136/neurintsurg-2019-SNIS.48

Background and purpose Endovascular therapy is associated with improved clinical outcomes in patients presenting with large vessel occlusions (LVO) however outcomes are typically worse in patients presenting as inter-facility transfers. A further understanding of the sources and impact of transfer delays is essential to improving outcomes in this population.

Methods Data were analyzed from consecutive acute ischemic stroke patients with proximal large vessel occlusions (LVO) transferred to our comprehensive stroke center for consideration of endovascular therapy. The following variables were studied: door-in-door-out time (DIDO), baseline NIHSS/mRS, initial CT ASPECT, site of LVO, treatment and clinical outcome.

Results 309 patients transferred from 14 referral hospitals to our CSC during the study period (January-December 2016). 61 (20%) had a proximal anterior LVO (53) or basilar artery occlusion (8). 40 (66%) underwent endovascular thrombectomy. 21 (34%) did not undergo endovascular thrombectomy - due to clinical improvement (33%), large core or poor ASPECTS (48%), high baseline disability (5%) and hemorrhagic transformation (5%). Median DIDO time in the endovascular thrombectomy group (98.5 minutes) was significantly better (p value=0.001) than the Median DIDO time in patients who did not get endovascular thrombectomy (185 minutes). The likelihood decreased by 0.5% for receiving endovascular therapy and 0.25% for good outcomes for every minute of DIDO.

Conclusions Shorter DIDO time is associated with higher likelihood of receiving endovascular therapy and good outcomes. DIDO may be used as a clinical performance metric for stroke referring hospitals.