

petrous segment of the ICA. Angiography and CTA confirmed pseudoaneurysm obliteration and complete vessel occlusion. Three-month follow-up CTA demonstrated stable vessel occlusion. Eleven months following ICA sacrifice, she started to complain of throat irritation and difficulty swallowing. During a scheduled sinus debridement, exposed coils were visualized in the right nasopharynx. CTA revealed vessel wall dehiscence with extrusion of coils into the nasopharynx but continued occlusion of the vessel. The exposed coils were clipped and extracted endoscopically for symptomatic relief. Three-month follow-up angiogram confirmed stable vessel occlusion and patient has remained asymptomatic.

Conclusion CBS can be a rare and devastating complication of head and neck surgery, often requiring immediate endovascular treatment. Coil migration is a rare complication following cerebral pseudoaneurysm obliteration via endovascular vessel sacrifice. When a patient has a partially extruding coil, it is imperative to obtain imaging and treat as soon as possible to avoid further coil migration and possible airway compromise.

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E-084

RECONSTRUCTIVE AND DECONSTRUCTIVE ENDOVASCULAR TREATMENT OUTCOMES OF CAROTID BLOWOUT SYNDROME

¹A Sweidan*, ²A Schnure, ³I Yuki, ¹R Fujitani, ²S Suzuki. ¹University of California, Irvine, Orange, CA; ²Neurosurgery, University of California, Irvine, Orange, CA

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Introduction Carotid blowout syndrome (CBS) is a rare but dreaded complication of head and neck cancer with high mortality. Management of CBS requires a multidisciplinary approach; nevertheless, endovascular therapy remains the cornerstone in rendering hemostasis. Literature routinely describes successful hemostasis with either deconstructive (artery take down) or reconstructive (stenting or bypass) approach. Previous retrospective analysis suggests that outcomes are predicted by clinical severity at presentation, not treatment type.

Methods Single-center, retrospective case review of endovascular treatment of CBS and outcome at University of California, Irvine.

Results Five cases of CBS were identified between 2012 to 2017. All patients were head and neck cancer treated with radiation. Of the five cases, one case failed to identify the source of bleeding which required open surgical ligation. In the remaining four patients, three achieved hemostasis with

reconstruction, while the fourth was treated with deconstruction. In one of the three cases, reconstructive over deconstructive technique was chosen because the patient had bilateral lesions and previous embolization at the bleeding site failed to maintain hemostasis. All four patients were discharged from the hospital without any further complications related to the procedure achieving hemostasis. Perioperative mortality, stroke and infection rate was not identified. In the case of surgical ligation, the patient developed minor local site infection which was treated with antibiotics successfully.

Endovascular approaches permit evaluation of collateral circulation in situations where target artery warrants take down. Therefore, concurrent cerebral angiogram with endovascular therapy by way of stenting or sacrificing the target artery with embolic materials has become the alternative in otherwise inoperable condition as an emergent standard of care.

The figure shows an illustrative case of CBS with massive contrast extravasation (A), which was treated with a balloon mounted covered stent (B) due to bilateral lesions, and complete hemostasis was achieved (C).

Conclusion In our retrospective study we demonstrate continued endovascular therapy as a means of treatment for CBS to achieve emergent hemostasis. As previous literature describes successful hemostasis with either deconstructive or reconstructive technique; herein we describe four cases that required endovascular intervention with successful emergent hemostasis.

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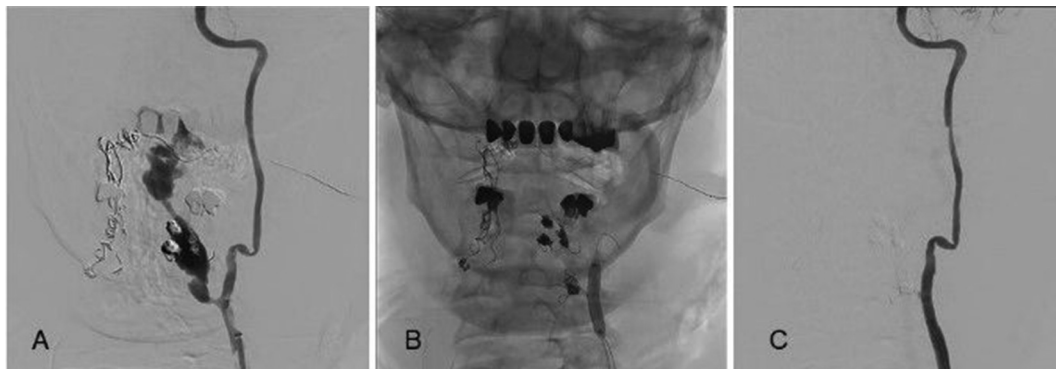
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CEREBRAL ISCHEMIC EVENTS AMONG PATIENTS UNDERGOING CAROTID ARTERY STENTING WITH OR WITHOUT EMBOLIC PROTECTION DEVICE-MULTICENTER REVIEW

¹Y Lodi*, ²V Reddy, ³S Javed, ⁴T Wong, ¹S Multani, ⁵W Elnour, ⁶A Harouni. ¹Neurology, Neurosurgery and Radiology, Upstate Medical University, Binghamton/UHS-Wilson Medical Center, Johnson City, NY; ²Neurology, Neurosurgery and Radiology, UHS-Wilson Medical Center/Upstate Medical University, Binghamton, NY, Johnson City, NY; ³Neurology, Neurosurgery and Radiology, UHS-Wilson Medical Center/Upstate Medical University, Binghamton, Johnson City, NY; ⁴Neurology and Neurosurgery, Maimanides Medical Center, Brooklyn, NY; ⁵Neurology and Neurosurgery, Upstate Medical University, Binghamton/UHS-Wilson Medical Center, Johnson City, NY; ⁶Department of Computer Science, Fort Hays State University, Hays, KS

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Carotid artery stenting (CAS) with distal protection device (DPD) for stenosis 70% or higher is considered an



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