diverters for a better understanding of comparative safety and effectiveness among the different devices.

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E-130 USE OF WALRUS BALLOON GUIDE CATHETER FOR PROXIMAL FLOW ARREST DURING NEUROINTERVENTIONAL PROCEDURES

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Introduction The use of balloon guide catheters (BGCs) for proximal flow arrest during neurointerventional procedures is limited due to incompatibility of these catheters with large-bore aspiration catheters and difficulty in device navigation. The objective of our study was to describe the use of Walrus (Q'Apel Medical, Fremont, CA), a new 8-French (F) BGC, with a variety of aspiration catheters and procedures requiring flow arrest.

Methods Consecutive cases using Walrus BGCs for proximal flow arrest during mechanical thrombectomy for acute stroke cases was recorded. Procedure indication, vessel occlusion site, technique, first-pass effect (modified thrombolysis in cerebral infarction score of 2C or 3 after first recanalization attempt), and complications were recorded and evaluated statistically.

Results Our study included 57 patients: all (100%) underwent mechanical thrombectomy. Besides mechanical thrombectomy, the Walrus BGC was used in conjunction with the following techniques: stent retrieval in 2 patient (3.5%), Solumbra in 41 (71.9%), and aspiration-first in 14 (24.6%). Eight different aspiration catheters were used in 56 of these 57 procedures. First-pass effect was achieved in 36 (63.2%) of 57 procedures. Four cases (7.0%) experienced intraoperative complications and 2 (3.5%) died during in-hospital stay.

Conclusion Our study demonstrates Walrus BGC as an excellent 8F navigable guide catheter compatible with most available aspiration catheters. With a larger inner diameter and compatibility with most available aspiration catheters, it can be used to achieve proximal flow arrest during mechanical thrombectomy and possibly for other neurointervention procedures in the future.

Abbreviations and acronyms ADAPT, a direct aspiration first pass technique; BGC, balloon guide catheter; F, French; FPE,

first-pass effect; ICA, internal carotid artery; ID, inner diameter; mFPE, modified first-pass effect; mRS, modified Rankin scale; mTICI, modified thrombolysis in cerebral infarction; OD, outer diameter; STRATIS, Systematic Evaluation of Patients Treated with Neurothrombectomy Devices for Acute Ischemic Stroke

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E-131 TRANSFEMORAL VERSUS TRANSRADIAL APPROACH FOR CEREBRAL ANGIOGRAPHY: A PATIENT PREFERENCE SURVEY

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Introduction The neurointerventional field is going through a paradigm shift towards a radial first approach, following lessons from interventional cardiology. The transradial approach for endovascular interventions have certain advantages over the transfemoral approach, such as less complications related to access-site, less post procedural pain, earlier deambulation and shorter hospital stay. To the best of our knowledge, there are no studies assessing the patients' preference for one approach over another.

Methods Our institution's prospectively maintained database of cerebral digital subtraction angiographies was retrospectively searched to identify patients who underwent both transradial and transfemoral approaches between January 2011 and January 2021. We included patients who underwent both approaches in distinct occasions within time period of the study and those who required switching from one approach to another during the same procedure. Electronic medical records of each patient were accessed to extract the phone number provided for clinical follow-up. Three medical students conducted phone interviews using a standardized questionnaire. Three contact attempts with 3 days of interval was made for each patient before considering them as lost to follow-up. Patients were interviewed with 2 major questions. The first was regarding their approach of choice for an eventual next procedure, having the options of radial, femoral or no preference. The second question addressed the reasons behind their choices, being able to choose as many as necessary from the following common complaints related to a cerebral angiogram: pain, bruising, complications, recovery time, mobility, failure of one approach and comfort of puncturing the respective area. If no preference, patients were asked if they think it is a physician's decision or if both approaches were similar to them.

Results Forty-four patients were successfully contacted. In response to the initial question "If you were to undergo a cerebral angiogram again, would you rather receive a radial or a femoral approach?", 70.4% answered "Radial", 20.5% answered "Femoral" and 9.1% said "no preference". From those patients who chose "Radial", the subsequent question "What reasons influenced your answer?" was answered as following: pain (48.4%), bruising (51.6%), complications (25.8%), recovery time (67.8%), mobility (29%), failure of the other approach (0%) and comfort of puncturing the