significant lower rate of complete and adequate aneurysm occlusion for larger WEB widths (table 2), even in aneurysms with adequate WEB LC (table 3). Further, there was a statistically-significant lower rate of retreatment in aneurysms treated with 4mm and 5mm WEBS (3%) compared to 6 to 11mm WEBS (18%, p-value 0.04).

Conclusion The efficacy of aneurysm occlusion with WEB decreases with increasing WEB width despite attaining adequate WEB LC. Although attaining greater WEB LC when using larger WEBS, when technically-feasible, may increase the likelihood of complete and adequate aneurysm occlusion at follow-up, proper operator and patient expectations should be set prior to treatment.

Disclosures J. Delgado Almandoz: 2; C: Microvention/Terumo. Y. Kayan: 2; C: Microvention/Terumo. A. Copelan: None. J. Scholz: None.

Abstract O-006 Figure 1

<table>
<thead>
<tr>
<th>WEB Width</th>
<th>Complete Occlusion (%)</th>
<th>Adequate Occlusion (%)</th>
<th>Retreatment (%)</th>
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</thead>
<tbody>
<tr>
<td>4mm (N=16)</td>
<td>100</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>5mm (N=13)</td>
<td>100</td>
<td>100</td>
<td>0</td>
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<tr>
<td>6-7mm (N=14)</td>
<td>93</td>
<td>63</td>
<td>7</td>
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<tr>
<td>8-11mm (N=8)</td>
<td>36</td>
<td>38</td>
<td>13</td>
</tr>
<tr>
<td>p-value: 0.007</td>
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</tbody>
</table>

Abstract O-005 Figure 1

Comparative intracranial aneurysm occlusion between on-label and off-label treatments with the Pipeline Embolization Device (PED). Significantly lower rates of complete and adequate aneurysm occlusion were observed with larger WEB widths, even in aneurysms with adequate WEB LC. A statistically significant lower rate of retreatment was observed in aneurysms treated with 4mm and 5mm WEBs (3%) compared to 6 to 11mm WEBs (18%, p-value 0.04).

Discussion In real-world practice, off-label uses of PED can achieve similar safety and efficacy to on-label uses, though there may be a slightly higher rate of ischemic complications in off-label uses. Expert judgment is a useful supplement to official guidelines when assessing reasonable PED use beyond its approved indications.

Disclosures S. Cler: None. D. Lauzier: None. A. Kansagra: 2; C: Penumbra, Microvention, iSchemaView.
derived from Fractional Flow Reserve without induced hyperemia. An FPR, with \( \%\Delta P < 25\% \) (equivalent to \( > 0.75 \) FPR), is a strong indicator of patent artery flow. FPR during balloon-stent deployment was simulated using Computational Fluid Dynamics (figure 1b) and validated using benchtop modeling in a circle of Willis (CW) vessel phantom equipped with real-time branch pressure and flow monitoring.

**Results**

A balloon-stent with a stent ID > 56% of parent artery ID maintained \( \%\Delta P < 25\% \) during deployment and will minimize ischemic risk. A balloon-stent device can temporarily provide aneurysm neck protection during complementary device deployment while maintaining blood flow in the parent artery. A 2.6F Penumbra Velocity, jailed next to a balloon-stent device permitted an inflation ID > 56% of parent artery ID, will maintain \( \%\Delta P < 25\% \) during deployment and will minimize ischemic risk. The prototype maintained safe FPR and parent vessel during in vitro and CFD simulations.

**Conclusion**

A balloon-stent device can provide neuro-interventional surgeons with a larger time-frame to deploy embolic without blood flow arrest and the need for repeated balloon inflation/deflations. In addition, this novel medical device has the potential to provide a smooth surface at the aneurysm neck for consistent device placement, minimize parent vessel trauma, eliminate ischemic effects distal to the parent artery, and minimize intra-saccular flow remnants pre- and post-treatment. Prototyping work on the balloon-stent device is currently underway.

**Disclosures**

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**Background**

Aneurysmal subarachnoid hemorrhage (aSAH) patients frequently suffer from vasospasm. We analyzed the association between absence of early angiographic vasospasm and early discharge.

**Methods**

All treated aSAH patients (August 1, 2007-July 31, 2019) at a single tertiary center were reviewed. Patients undergoing diagnostic digital subtraction angiography (DSA) on post-aSAH days 5 to 7 were included in the analysis; cohorts with and without angiographic vasospasm (angiographic reports by attending neurovascular surgeons) were compared. Primary outcome was hospital length of stay; secondary outcomes were ICU length of stay, 30-day return to the emergency department (ED) and poor neurologic outcome, defined as a modified Rankin Score (mRS) score > 2.

**Results**

A total of 298 patients underwent DSA on post-aSAH day 5, 6, or 7. Most patients (n=188, 63%) had angiographic vasospasm, whereas 110 patients (37%) did not. The no-vasospasm cohort had a significantly lower mean length of hospital stay (18.0±7.1 days) than the vasospasm group (22.4±8.6 days) (p<0.001). The 2 cohorts did not differ significantly in the percentage of patients with mRS scores > 2 at last follow-up or those returning to the ED before 30 days. After adjustment for Hunt and Hess scores, Fisher grade, admission Glasgow Coma Scale score, and age, logistic regression analysis...