reported chronic headaches before embolization. With a mean follow-up of 489 (173) days, 8 of the 9 patients reported improvement of chronic headaches, with 7 having complete resolution. For these 9 patients, the mean HIT-6 score before was significantly higher than after embolization (64 [7.1] vs 40 [9.1], \( p<0.001 \)).

**Conclusion**
In patients with chronic headache undergoing MMA embolization for a cSDH, the majority reported improvement of headaches after the procedure. Future prospective studies are warranted to assess the utility of MMA embolization for chronic headaches.

**Disclosures**

(20%) reported chronic headaches before embolization. With a mean follow-up of 489 (173) days, 8 of the 9 patients reported improvement of chronic headaches, with 7 having complete resolution. For these 9 patients, the mean HIT-6 score before was significantly higher than after embolization (64 [7.1] vs 40 [9.1], \( p<0.001 \)).

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**Disclosures**

**Introduction**
In mechanical thrombectomy (MT) candidates, tenecteplase (TNK) has shown improved reperfusion and outcomes. Therefore, in October of 2020, we transitioned to TNK as the primary thrombolytic for patients presenting with large vessel occlusion acute ischemic stroke (LVOAIS). We describe our initial experience.

**Methods**
In this retrospective study, demographic, clinical, and imaging information from patients with LVOAIS treated with TNK was collected. Data was compared to a group treated with MT and intravenous alteplase (tPA).

**Results**
Between October 2020 and March 2021, 14 patients received TNK for LVOAIS. Mean age was 71.4 years. Of the TNK patients, 5 presented directly to the comprehensive stroke center (CSC), and 9 were transferred from telestroke spoke sites within the system. Median initial NIHSS was 16. All patients had either an LVO on CTA, or high suspicion based on high NIHSS. Occlusion locations included the MCA in 9 (7 M1, 2 M3-4 with CTA obtained after TNK), ACA 1, PCA 1, ICA terminus 1, and 2 with occlusion involving the internal carotid artery (ICA) from the origin to the terminus. Three patients (21%) improved clinically prior to MT and did not undergo this intervention, and 2 (14%) had a cerebral angiogram demonstrating recanalization without MT. One patient with occlusion from ICA origin to terminus underwent revascularization of the ICA origin with distal spontaneous recanalization. Eight patients underwent MT with 7 achieving TICI 2b-3. Symptomatic hemorrhage (SICH) rate was 7.1%. Length of stay (LOS) was 4.4 days, with median discharge NIHSS of 4. In comparison, of patients who received tPA prior to MT none recanalized prior to MT, median discharge NIHSS was 6, rate of SICH was 5.1% and LOS was 8.54 days.

**Discussion**
In our initial experience in a small cohort, the recanalization rate was high with TNK in patients with LVOAIS, with 36% of TNK patients not requiring MT either due to clinical improvement or recanalization pre-MT. In comparison, no patient who received tPA prior to MT none recanalized prior to MT, median discharge NIHSS was 6, rate of SICH was 5.1% and LOS was 8.54 days.

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Elevated D-dimer levels predicts mortality in COVID-19 with stroke: analysis of multi-center electronic health record data
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Introduction Coronavirus disease (COVID-19) has been associated with coagulopathy, and D-dimer levels have been implicated as predictors of disease severity. In this study, we examined whether D-dimer remains useful to predict mortality in COVID-19 patients presenting with acute ischemic stroke (AIS).

Methods We conducted a retrospective cohort study using the Optum® de-identified COVID-19 Electronic Health Record (EHR) dataset. Patients were included if they were 18 and older, were hospitalized within 7 days of confirmed COVID-19 from March 1, 2020 - November 30, 2020, and were tested for D-dimer during their hospitalization. ICD-9 and 10 diagnostic codes were used to identify AIS and comorbidities. D-dimer level was evaluated using receiver-operator curve analysis for the optimal threshold to predict in-hospital mortality and Kaplan-Meier survival curves were constructed. Risks of in-hospital mortality were compared between patients with D-dimer levels below and above the cutoff and risk ratios (RRs) were estimated adjusting for baseline characteristics and clinical variables.

Results Among 15,250 patients hospitalized with COVID-19 positivity, 285 presented with AIS at admission (2%). Patients with AIS were older (median age 70 [60-79] vs 64 [52-75]) and had higher prevalence of congestive heart failure, hypertension, diabetes, vascular disease and atrial fibrillation. D-dimer levels at admission were greater for patients presenting with AIS (median [IQR], 1.42 [0.76-3.96] µg/ml feu) compared to those without AIS (0.94 [0.55-1.81] µg/ml feu) and peak levels were also greater for patients with AIS (3.86 [1.23-15.58] vs 1.42 [0.76-3.96] µg/ml feu). Peak D-dimer level was a good predictor of in-hospital mortality among all patients (c-statistic 0.774 [95% CI 0.764-0.784]) and among patients with AIS (c-statistic 0.751 [95% CI 0.691-0.810]). The optimum cutoff threshold was identified as 2.07 µg/ml feu with 72% sensitivity and 70% specificity, and elevated peak D-dimer level above this cut-off was associated with almost 3 times increased mortality (adjusted RR 2.89 [95% CI 1.87-4.47]).

Conclusions Peak D-dimer levels above 5.15 µg/ml feu are associated with increased mortality in COVID-19 patients with AIS.