increase in size measuring 1.7 mm. At this point, with multi-
disciplinary team approach, we decided to consider securing
the aneurysm with endovascular approach. Patient also had
functional MRI and tractography to complete open surgical
planning evaluation if endovascular approach was unsuccessful.
Meanwhile patient’s neurological deficits were completely
resolved at approximately two month mark. Selective micro-
catheter angiographic runs on the day of treatment showed
that the aneurysm had side wall morphology (2.3 mm) with
parent perforator blood vessel having significant basal ganglia
territory supply. Considering inevitable sacrifice of the perfora-
tor while using endovascular approach, we proceeded with
open surgical clipping of the aneurysm. The aneurysm was
secured with surgical clipping preserving the parent perforator
data. Distal lenticulostriate aneurysms are uncommon pathol-
ogy. Considering very high risk of neurologic deficits with
either endovascular or open surgical approach, these lesions
need meticulous multidisciplinary team planning.

Disclosures M. Fayad: None. A. Elmashad: None. A. Kureshi:
None. J. Lima: None. C. Bruno: None. M. Ollenschleger:
None. I. Kureshi: None. T. Mehta: None.

Introduction Early evidence suggests that MMA (Middle
Meningeal Artery) embolization for prevention of cSDH
(chronic subdural hematoma) is safe and efficacious. A sig-
nificant number of cSDH patients are elderly with higher
likelihood of relatively difficult aortic arch anatomy. Trans-
radial approach for intracranial embolization has been asso-
ciated with lower access site complications, lower cost, and
higher patient satisfaction. However, catheterizing the left
MMA via trans-radial approach can be challenging and
could be associated with higher risk of guide catheter her-
niation into the aortic arch. In this single center retrospec-
tive review, we compare the outcomes of trans-radial
approach utilizing reverse angle guide catheter with trans-
femoral approach.

Method We performed a retrospective review of all patients
who underwent left MMA embolization between 01/01/2020
- 03/01/2021 for cSDH. For all trans-radial approach cases, we
used a 6 F 90 cm Envoy (Codman & Shurtleff, Inc., Rayham,
MA) Simmons 2 shape guide catheter keeping its distal tip in
the left common carotid artery. Also, in all trans-radial cases
we used a 5 F 125 cm Sofia (Microvention, Aliso Viejo, CA)
intermediate catheter to mitigate any possibility of embolic
material embolizing to the left internal carotid artery while
pulling back the microcatheter. All trans-femoral cases were
performed using a 5 F 90 cm Enovy angled tip Guide catheter
or 5 F 120 cm Penumbra Select (Penumbra, Alameda, CA)
angled tip catheter. Variables including age, gender, access site
complications, total fluoroscopy time, radiation dose, initial
size of subdural at first follow up, midline shift size before
embolization, and reduction in SDH size on initial follow up
head CT.

Results A total of 20 patients who underwent left MMA
embolization with 7 trans-radial and 13 trans-femoral cases
during the specified time period. There were no access site
related complications in either group. Proceduralists were able
to obtain adequate access in all cases without requiring to
switch the route from trans-radial to trans-femoral or vice
versa. There was no significant difference in mean patient age
for trans-radial versus trans-femoral groups (72.7 years vs.
74.6 years, p=0.7). The mean fluoroscopy time for trans-
radial vs trans-femoral approach of left MMA embolization
was 24.75 vs 43.12 (P=0.012). The mean radiation dose of
trans-radial vs trans-femoral was 14973.2 vs 22670.6 mcGym2
(P=0.072).

Conclusion Use of 6F reverse angle guide catheter (Simmons 2
shape) may represent a relatively safe and proficient approach
to embolizing left MMA with trans-radial approach in elderly
patients with complex and tortuous aortic arch anatomy.

Disclosures M. Fayad: None. S. Patel: None. A. Elmashad:
None. J. Lima: None. M. Ollenschleger: None. C. Bruno:
None. I. Kureshi: None. T. Mehta: None.