final reperfusion grade: full reperfusion (eTICI3) vs. non-full reperfusion (eTICI<3). The secondary outcome included a 90-day mRS shift analysis. Safety measures included symptomatic intracranial hemorrhage (sICH) and 90-day mortality.

**Results** Among 823 patients eligible for the analysis, 564 were matched in a 1:1 ratio. The two groups were balanced in baseline and clinical characteristics. Final reperfusion grade significantly modified the effect of pre-procedural IV-tPA on functional independence (P=0.008), where bridging therapy showed higher rates of functional independence (63.2% vs. 51.6%), adjusted OR 2.09, 95%CI[1.03–4.20], P=0.039) compared to non-bridging therapy in patients with full reperfusion. However, in non-fully reperfused patients, the rates of functional independence were comparable (40.3% vs. 43.7%), adjusted OR 0.62, 95%CI[0.31 to 1.25], P=0.18 among both therapies. Likewise, bridging therapy was associated with 90-day mRS shift to a lower degree of disability (adjusted common OR 1.59, 95%CI [1.03–2.48], P=0.039) in fully reperfused but not in non-fully reperfused (adjusted common OR 0.98, 95%CI [0.65–1.46], P=0.91). The effect size of pre-procedural IV-tPA on functional independence was comparable across different subgroups (Figure 1). The rates of sICH and 90-day mortality were similar among bridging vs. non-bridging in fully and non-fully reperfused patients.

**Conclusion** The impact of pre-procedural IV-tPA on functional outcome was evident in patients who achieved full reperfusion compared to non-fully reperfused patients. Our findings could be related to the effect of the remaining tPA in circulation on improving intracranial microcirculation and hence preventing the no-reflow phenomenon. Further studies are warranted to validate our results.

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