and in-hospital tele-stroke expertise based on a spoke/hub stroke network. Data from 38 hospital network between December 2014 and January 2018 were collected.

Results The study cohort consisted of 9702 patients. The majority were females (n= 3556, 55.3%) and the mean age was 67 (67 ± 16.7, 66.7 – 67.4, 26 -122). Of all patients, tissue plasminogen activator (tPA) was recommended in 1313 (16.3%) patients, and from these, 810 (61.7%) patients were actually given tPA. As for endovascular intervention, only 187 (2.3%) patients underwent mechanical thrombectomy at our institution.

Conclusion Tele-stroke networks have proven to be a pivotal development in the treatment of strokes, especially those that are remote. With the additional expertise and the shorter duration from onset to diagnosis to treatment, these networks have substantially improved patient care and decreased healthcare costs, avoiding unnecessary transfers from spoke hospitals to hub.


**P-007 RETAINED RADIAL CATHETERS ASSOCIATED WITH VARIANT RADIAL ANATOMY IN NEUROINTERVENTIONAL PROCEDURES**

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**Background** Transradial artery access (TRA) for neurointerventional procedures is gaining widespread acceptance. However, complications that were previously rare may arise as TRA procedures increase. Herein, a series of retained catheter cases are reported with a literature review.

**Methods** All patients who underwent a neurointerventional procedure during a 23-month period at a single institution were retrospectively reviewed for a retained catheter in TRA cases. In cases of retained catheters, imaging was reviewed for anatomical variances in the radial artery, and clinical and demographic case details were analyzed.

**Results** A total of 1386 nondiagnostic neurointerventional procedures were performed during the study period, 631 (46%) initially via TRA. The 631 TRA cases were performed for aneurysm embolization (n=221, 35%), mechanical thrombectomy (n=116, 18%), carotid stent/angioplasty (n=40, 6%), arteriovenous malformation embolization (n=38, 6%), and other reasons (n=216, 34%). Thirty-nine (6%) TRAs crossed over to femoral access, most commonly because the artery of interest could not be catheterized (26/39, 67%). A retained catheter was identified in 5 cases (1%), and 1 (0.2%) patient had an entrapped catheter that was recovered. All 6 patients with a retained or entrapped catheter had aberrant radial anatomy, with 4 patients having a brachialradial artery.

**Conclusion** Retained catheters for neurointerventional procedures performed via TRA are rare. However, this complication may be associated with variant radial anatomy. With the increased use of TRA for neurointerventional procedures, awareness of anatomical abnormalities that may lead to a retained catheter is necessary. We propose a simple protocol...
Abstract P-007 Figure 2
to avoid catheter entrapment, including in emergent situations such as TRA for stroke thrombectomy.
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P-008 PULSATILE TINNITUS AND SUBCLINICAL IDIOPATHIC INTRACRANIAL HYPERTENSION. AN EVALUATION ON MRI SIGNS

Purpose To investigate the prevalence of intracranial and ophthalmological signs of Intracranial Hypertension (IH) on MRI in patients with Pulsatile Tinnitus (PT).

Materials and Methods We included all patients assessed with PT in our center. We included in the study all patients with PT who underwent MRI between January 2020 and December 2021. Both treated and untreated patients were considered and, in the case of treatment only pre-treatment MRIs were evaluated. We evaluated imaging and undiagnosed ophthalmological signs of intracranial hypertension. Exclusion criteria included non-pulsatile tinnitus and primary diagnosis of IIH or venous thrombosis.

Results We included four-hundred-fifteen patients in our study. MRI imaging was evaluated for IH signs and we also included neuroophthalmological assessment if present. Our preliminary results on 20% of the patients demonstrate a high prevalence of both intracranial and ocular MRI signs of IIH. The prevalence of both intracranial and ocular MRI signs of IIH were preliminary results on 20% of the patients demonstrate a high prevalence of both intracranial and ocular MRI signs of IIH. In these preliminary results, 38% of patients presented with partial empty sella, 36.9% of subjects presented with extraocular muscle tortuosity, 35% of patients presented with dilated episcleral veins, and 40% presented with flattening of the posteriopic globe. The venous outflow impairment was assessed in 64.6% of patients who presented with bilateral optic nerve sheath distension, 49% presented with bilateral optic nerve sheath distension, 49.2% presented with bilateral optic nerve sheath distension, and 40% presented with optic nerve head protrusion.

Conclusion This study demonstrates a high prevalence of IH signs in patients presenting with PT, suggesting the possibility of initial signs of intracranial hypertension probably related to venous outflow impairment. A neuro-ophthalmological assessment could be considered for this subgroup of PT patients with signs of IH.

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P-009 NATURAL HISTORY, ANGIOGRAPHIC PRESENTATION AND OUTCOMES OF ANTERIOR CRANIAL FOSSA DURAL ARTERIOVENOUS FISTULAS

Introduction Anterior cranial fossa dural arteriovenous fistulas (ACF-dAVFs) have a high risk of rupture. The most important determinant of symptoms and risk of hemorrhage is the pattern of venous drainage. The incidence of venous sinuses in the anterior cranial fossa leads to drainage through delicate small cortical veins that can easily bleed. We present a comprehensive analysis of natural history, angiographic presentation, and outcomes of a large cohort of ACF-dAVFs from the CONDOR database.

Method The CONDOR consortium is a repository that contains data from 1077 dural arteriovenous fistulas (dAVF) diagnosed in 12 international centers. The consortium includes patients that were diagnosed with dAVFs from 1990 to 2017. dAVFs were classified into various groups depending on the anatomical location. Data from ACF-dAVFs was analyzed from the CONDOR repository.

Results A total of 60 ACF-dAVFs were included. The mean age was 61 ± 12 and 63% (38/60) were male. Sixty-three percent (38/60) of ACF-dAVFs had a symptomatic presentation. Intracranial hemorrhage was the most common presentation 58% (22/38). The ethmoidal artery was the most common arterial feeder (66%, 40/60). Instead of draining directly to a sinus, most ACF-dAVFs (93%, 56/60) drained through cortical veins. Drainage through cortical veins predicted symptomatic onset (OR 9.42, CI 1.98-37.9, p = 0.01) (table 1). Ultimately, most ACF-dAVFs with cortical venous drainage, drained into the superior sagittal sinus (60%, 34/56). Signs of venous ectasia were present in 53% (32/60) of patients. Eighty-eight percent (53/60) of ACF-dAVFs were treated. Microsurgery was the most successful modality of treatment achieving fistula closure in all cases (n = 35).