Successful FP reperfusion was achieved in 30 patients (67%). Successful and complete final reperfusion were achieved in 43 (96%) and 42 (93%) patients respectively. Median NIHSS in all treated patients improved from 17 to 4. Median mRS developed from 5 to 4.

Conclusion With the pRESET 6–50 achieves high successful FP reperfusion rates and a high overall rate of reperfusion in patients with AIS and LVO.

REFERENCES

Do you have any conflict of interest to declare?: No

COMPLETE SUDDEN RECANALIZATION: THERE IS HOPE BEYOND THE FIRST PASS EFFECT

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Introduction Achieving complete recanalization in a minimum number of attempts is the main procedural objective of mechanical thrombectomy. We aimed to explore the effect of the recanalization pattern in patients with final complete recanalization.

Methods We performed a retrospective analysis of patients with terminal carotid internal artery or M1-middle cerebral artery occlusion and complete recanalization (eTICI 2c-3) from 2014 in our center. Complete Sudden Recanalization (cSR) was considered when eTICI varied from 0–1 to 2c-3 without an interim partial recanalization step (2a or 2b) (progressive recanalization, PR). We explored the effect of cSR on clinical outcome compared with progressive complete recanalization.

Results Among four hundred patients with complete recanalization, in 301 was achieved with a cSR pattern. There were no differences between groups in terms demographic or clinical data and use of intravenous rtPA (42.2% vs 44.4%, p=0.69). The rate of terminal carotid artery occlusion (28.6% vs 44.4%, p=0.003), median number of passes (1 (IQR 1–2) vs 2 (2–3), p<0.001) and time from puncture to recanalization (27 (IQR 18–43) vs 46 (34–66) minutes; p<0.001) were lower in cSR group.

At 90 days cSR was an independent predictor of good functional outcome (57.8% vs 44.4%, p=0.038). Compared with first pass effect, cSR after the first pass didn’t worsen the rate of good functional outcome (57.6% vs 58.6%, p=0.889).

Conclusion Among patients with a large vessel occlusion, the complete sudden recanalization pattern was a predictor of functional independence even when it did not occur in the first attempt.

REFERENCES

Do you have any conflict of interest to declare?: No
P89 "NOT ONLY CAROTID: TWO UNUSUAL CASES OF TREATMENT OF STENO-OBSTRUCTIONS"

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Introduction The persistent primitive hypoglossal artery (PPHA) is the second most common fetal residue carotid-basilar anastomosis with an estimated incidence of 0.02%–0.30%.

A case of an awake ischemic stroke from internal carotid stenosis and basilar tip obstruction and a case of internal carotid artery restenosis, both associated with persistent primitive hypoglossal artery, are reported and summarized in this abstract.

Methods Case 1: Female, 42-year-old, was hospitalized with wake-up stroke and rapid worsening of symptoms up to coma; MRI revealed cerebellar and occipital lesions in DWI and the MR-Angiography showed the obstruction of the basilar tip. The patient was taken to the Angio-suite to undergo an i.a. mechanical thrombolysis. Cerebral angiography revealed bilateral vertebral hypoplasia, thrombotic near occlusion in left ICA and ipsilateral PPHA. After basilar recanalization ICA thrombosis was treated deploying a self-expanding stent. The procedure showed a complete recovery of the vessel lumen.

Case 2: Female, 84-year old, was hospitalized with asymptomatic restenosis of the left internal carotid after CEA, and right ICA stenosis; Carotid duplex ultrasonography showed ulcerated plaque causing 65% stenosis (NASCET criteria). During endovascular treatment, cerebral angiography revealed a left PPHA. CAS was performed using a distal protection device in ICA; at final check the complete regain of the vessel lumen was observed and no complications were reported.

Conclusions The persistence of fetal anastomosis between carotid and basilar artery would represent a posterior cerebral circulation risk for ischemia and embolic infarction; in these cases the management of carotid steno-obstructions is challenging and requires special considerations.

REFERENCES

Do you have any conflict of interest to declare?: No