Abstract E-134 Table 1

Article	Stent	Ruptured/Unruptured	Mortality (%)	Complete Occlusion (%)
Madjidyar J et al.	phosphoryl-bonded FDS	Ruptured	1/9 (11.1)	6/9 (66.7%)
Eide PK et al.	Unknown	Ruptured	1/7 (14.3)	Unknown
Tanburoglu A, Andic C	Unknown	Ruptured	0/6 (0)	5/6 (83.3)
Incandela F, et al.	PED (3/6), FRED (2/6), DED (1/6)	Ruptured	0/6 (0)	6/6 (100)
Gopinath A, et al.	PED Shield (5/6), SILK Vista Baby (1/6)	Ruptured	1/6 (16.7)	4/6 (66.7)
Griessenauer CJ, et al.	PED	Both	N/A	44/45 (97.8)
Capocci R, et al.	PED (6/8), Surpass (2/8)	Ruptured	0/8	9/9 (100)
Mokin M, et al.	PED	Both	1/38 (2.6)	28/32 (87.5)
Ryan RW, et al.	PED	Ruptured	2/13 (15.4)	5/9 (55.6)
Cerejo R, et al.	Unknown	Ruptured	0/8 (0)	6/8 (75)
Linfante I, et al.	PED	Ruptured	1/10 (10)	9/9 (100)
Chalouhi N, et al.	PED	Ruptured	0/8 (0)	5/6 (83.3)

Currently, data primarily includes first-generation FDs. The implementation of surface-modified FDs limits the need for DAPT, which may provide an additional safety benefit in ruptured blister aneurysms and warrants further investigation.

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E-135 DEJERINE-ROUSSY SYNDROME IN THE SETTING OF RIGHT SIGMOID SINUS THROMBOSIS: A UNIQUE CASE REPORT

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Introduction Dejerine-Roussy Syndrome (DRS), also known as central post-stroke pain, is an unusual neuropathic pain syndrome in the central nervous system. Symptoms can originate from any vascular lesion or disease affecting the central somatosensory system. Most frequently the etiology is due to acute arterial infarction, with a high prevalence in lateral medullary syndrome. Few cases have been reported of DRS secondary to venous thrombosis. This case presents evidence of DRS secondary to right sigmoid sinus thrombosis.

Case Presentation Here we report the case of a 37-year-old male with a past medical history of hypertension, tibial and fibular fracture, status-post open reduction and internal fixation (ORIF), and recent right-sided cerebral venous thrombosis of the sigmoid sinus with residual left-sided weakness from January 2023. The patient presented to the hospital in March 2023, due to the sudden onset of severe left-sided pain with left arm weakness. On exam, he was found to have allodynia of left hemi-body: severe pain to light touch LUE, moderate pain to light touch left face, left chest, left abdomen, and LLE respecting the midline. Imaging studies including Computerized Tomography (CT) Angiogram of the Head and Neck, CT Brain Venogram, and CT Brain without contrast showed reduced flow in the right sigmoid sinus and no flow in the adjacent jugular vein, confirming a right sigmoid sinus thrombus. Magnetic Resonance Imaging (MRI) showed a small subcentimeter white matter focus of DWI hyperintensity in the left frontal centrum semi-ovale, presenting as a possible left hemispheric stroke, which does not account for the current symptomatology. Pertinent laboratory studies demonstrated an increase in thrombosis risk from Lupus anticoagulant PT at 13 and Antithrombin III Ag at 68 (L). He was treated with physical therapy/occupational therapy, and the pain was controlled gradually with amitriptyline 50mg nightly and Lyrica 50mg three times daily. Cardio-embolic workup was also completed including Transesophageal echocardiography (TEE), showing an intra-arterial aneurysm, but since it is present without a patent foramen ovale (PFO), it was deemed not significant.

Discussion This case illustrates the important clinical aspects and physical findings needed to diagnose DRS. The presence of focal allodynia and hyperalgesia with recent cerebrovascular incidents provides significant evidence for DRS. The purpose of this case is to provide awareness and to increase clinical suspicion of DRS during examination, especially in the setting of cerebral venous sinus occlusion as infarction alone may not present as atypical allodynia.

Disclosures S. Nittala: None. **C. Jara:** None. **D. Raza:** None. **J. Cazzaniga:** None. **D. Filippi:** None.

E-136 WHAT IS A CHALLENGING CLOT? A DELPHI CONSENSUS STATEMENT FROM THE CLOT SUMMIT GROUP

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Introduction Research into occlusion factors has substantially increased in recent years, including imaging, flow patterns, clot composition, histology, immunohistochemistry, and

biomechanical properties. However, integrating them into clinical practice to identify a challenging occlusion prior to clot retrieval is not well established.

Methods A modified DELPHI technique was used before and during CLOT SUMMIT 7.0, which included experts in thrombectomy and clot research from different specialties. Panelists answered three iterative question rounds, in which they indicated their certainty level on the association of 30 specific clot features as indicators for difficult-to-recanalize target occlusions. The features were grouped into 5 domains: histological, imaging, biomechanical, procedural, and clinical factors. The first round included open-ended questions and formed the basis for subsequent rounds, in which closed ended questions were used. Consensus was defined as $\geq$ 50% agreement among the panelists. Certainty was rated from 1 ('very uncertain') to 4 ('very certain') in the final round, and mean levels of 3.0 or greater were regarded as high certainty.

Results A total of 3 DELPHI rounds were performed, the last two in a live setting. Consensus was reached on 16 out of 30 questions, of which 8 were of high certainty (23%). Except for the clinical factors domain, all others had at last at least one clot feature with consensus and high certainty. Of those, the biomechanical domain produced the most clot features with consensus and high certainty (75%) while the imaging domain produced the least (8.3%). The 8 clot features were combined to produce a holistic definition of a challenging clot: A white coloured or calcified clot that's stiff, hard, sticky or adherent, that could be calcified on imaging, and during thrombectomy is difficult to pass and resistant to pulling. There was also consensus but with less certainty (2.6/4) that the endovascular (EVT) technique should be switched after the third unsuccessful attempt.

Conclusions A live DELPHI consensus from experts in thrombectomy and clot research suggest the features of a challenging clot, which most aptly describe a tough clot: A white coloured or calcified clot that's stiff, hard, sticky or adherent, that could be calcified on imaging, and during thrombectomy is difficult to pass and resistant to pulling. This may help clinicians and researchers focus on using and developing specialized tools for a priori identification of tough clots for swift recanalization.

Disclosures M. Mirza: 5; C; Cerenovus. **J. Ospel:** None. **P. Brouwer:** 5; C; Cerenovus.

E-137 ENDOVASCULAR TREATMENT OF CEREBRAL VASOSPASM WITH INTRAARTERIAL INJECTION OF VERAPAMIL AND NIMODIPINE. SINGLE CENTER EXPERIENCE

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The purpose of our research was to compere the course structural epilepsy, which is both the only manifestation of malformation and the debut of the disease in combination with intracerebral hemorrhage in patients (pts) with arteriovenous malformations (AVM) after endovascular and combined treatment using the Engel scale. The study is retrospective, non-randomized.

Material and Methods The study included patients with confirmed cerebral AVM by cerebral angiography data with concomitant epileptic seizures (both the only manifestation of the malformation and in combination with hemorrhage at the onset of the disease). The study took into account demographic characteristics (gender, age), AVM localization. Complications (mortality, disability) were assessed at each stage of treatment. The follow-up period average 3.5 years (range 1 to 7 years). All patients underwent endovascular embolization (EVE) at the first stage. In order to achieve total exclusion of the AVM from the bloodstream, in the absence of afferents available for embolization, further microsurgical (MS) or radiation (SRS) treatment was performed.

Abstract E-137 Table 1

Method of treatment	Only seizures (n=119)	Seizures with hemorrhage (n=31)
EVE	65 (43,3%)	12 (8%)
EVE + MS	29 (19,3%)	13 (8,7%)
EVE + SRS	25 (16,7%)	6 (4%)

Results A total of 301 patients with cerebral arteriovenous malformations with concomitant epileptic seizures were treated. Of these, 246 pts (81,7%) had only seizure and 55 pts (18,3%) had a combined type (hemorrhage and seizures at the onset of the disease). The gender distribution was as follows: 169 men's and 132 women's, average age 37 years (from 6 to 69 years). According to the Spitzler Martin gradation, the distribution of patients was as follows: I - 11 (3,7%) pts, II - 63 (20,9%), III - 126 (41,9%), IV - 68 (22,6%), V - 33 (10,9%). Out of 301 pts, 150 (49,8%) achieved total exclusion of the AVM, subtotal (90% or more) in 23 pts (7,6%), partial - 128 pts (46,6%). The distribution by treatment methods in total obliterated AVMs was as follows: EVE +MS 42 pts (28%); EVE+SRS 31 pts (20,7%); EVE 77 pts (51,3%). The distribution of patients according to the Engel scale (class 1) in patients with epileptic and combined (hemorrhage and epileptic seizures) type of malformation course after total shutdown is presented in the table below:

From 2009 to 2022 years, 301 pts with cerebral AVMs and seizures were treated. Complications were received: 1 death (0,3%), 2 pts (0,6%) with severe neurological deficit and 12 pts (3,9%) with incomplete recovery after surgery. Control over seizures is directly proportional to the volume of the malformation turned off.

Conclusion The treatment of structural epilepsy in patients with cerebral AVMs should include all available surgical methods to freedom from seizures in order to improve the quality of life of patients. The method of endovascular embolization is minimally invasive and effective method of treatment in the control of seizures in patients with AVM.

Disclosures K. Orlov: None. **A. Brusyanskaya:** None. **V. Berestov:** None.

E-138 INTRA-ARTERIAL THERAPY FOR CEREBRAL VASOSPASM AND DELAYED CEREBRAL ISCHEMIA AFTER SUBARACHNOID HEMORRHAGE AND ITS IMPACT ON REFRACTORY VASOSPASM

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