

Methods A 78-year-old man manifested by only headache. MRI showed abnormal flow voids in temporal lobe, with multiple large venous varices and dilated veins. Cerebral angiogram revealed DAVF at the left transverse sinus(TS). It was supplied by ipsilateral MMA and hypoglossal branch of ascending pharyngeal artery. Cortical venous reflux was evident from the isolated transverse sinus, forming multiple venous varices.

Results Transarterial embolization for ipsilateral MMA was performed with Onyx. There no more filling of the fistula from MMA, but residual filling and pial venous reflux from ascending pharyngeal artery (APA) hypoglossal branch. Before embolization of hypoglossal branch, position of the microcatheter tip was confirmed to be in the hypoglossal canal through 3D reconstruction images, to avoid lower CN deficit. Final angiogram showed complete occlusion of DAVF with no venous ectasia.

Conclusion DAVF with venous varix is defined as high risk for venous hypertension or hemorrhage. There is a possibility of lower CN injury during embolization for hypoglossal artery, so accurate knowledge of anatomical structures is essential. Transarterial embolization for DAVF with large venous varix is a safe and considerable treatment option, even when fed by hypoglossal artery.

Disclosure of Interest Nothing to disclose

P009/86

INFECTED GIANT PSEUDOANEURYSM OF EXTRACRANIAL INTERNAL CAROTID ARTERY WITH EXTREME VASCULAR TORTUOSITY: DIFFICULTY IN ACCESSING THE DEVICES IN ENDOVASCULAR TREATMENT

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Introduction Extracranial carotid artery pseudoaneurysms are rare and have high mortality rate with rupture. There is no treatment-guideline due to rarity and heterogeneity of cases.

Aim of Study We report a man presented with neck swelling, diagnosed as infectious giant pseudoaneurysm.

Methods A 76-year-old man admitted because of fever and neck swelling . He presented high fever and CRP level, with history of Covid-19 a month ago. Neck CT showed deep neck infection with enhanced lesion around left ICA. MRA showed a large pseudoaneurysm of left ICA. Cerebral angiogram confirmed a giant pseudoaneurysm of left proximal ICA. There was no collateral flow across Circle of Willis, even when compressing left CCA.

Results Endovascular treatment was chosen over surgery considering infection. Covered stenting was attempted, but failed to pass through curvature of CCA-ICA junction due to stiff device.

Surgery could not be considered because infection was not controlled despite antibiotics. After CRP was normalized, second treatment option using flow diverter was attempted.

Angiogram revealed dramatically increased size of pseudoaneurysm and severe narrowing of ICA distal to pseudoaneurysm, thought to be a mass effect by pseudoaneurysm. The catheterization to aneurysmal outflow failed continuously due to narrowing.

As the last option, we decided surgical treatment. Bypass through CCA-artificial graft-distal ICA was performed.

Conclusion When we deciding treatment strategy, surgery could not be considered due to uncontrolled infection and suggesting inflammatory/erosive changes. Because of no collateral flow, carotid sacrifice could not be considered. Endovascular treatment is preferred option, but treatment strategy should be personalized.

Disclosure of Interest Nothing to disclose

P010/89

ENDOVASCULAR TREATMENT OF CAROTID PETROUS SEGMENT GIANT SACCCULAR ANEURYSM PRESENTED WITH CEREBRAL ISCHEMIA

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Introduction Aneurysms of the petrous segment of the internal carotid artery are rare, usually asymptomatic but may present with a variety of symptoms.

Treatment options include medical, surgical and endovascular treatment.

Aim of Study To present a case of giant saccular aneurysm of petrous segment of internal carotid artery manifested with a cerebral ischemia and treated with flow diverter and coils placement.

Methods A 49 years old male patient was admitted to the hospital with right sided hemiparesis and dysarthria.

MR exam showed multiple acute ischemic focal lesions in the left centrum semiovale and basal ganglia and giant partially thrombosed left ICA petrous segment aneurysm. Double anti-aggregation treatment was initiated.

Three weeks later patient was shifted to our hospital. CTA confirmed existence of the aneurysm and remodeled petrous bony carotid canal and erosive changes of clivus.

The decision was made for endovascular treatment.

Flow diverter (4 mm x 35 mm) was placed over the neck of the aneurysm and 8 coils detached inside the aneurysm. Angiographic follow up showed stagnation of contrast media inside the aneurysm.

Double anti aggregation therapy was continued and corticosteroid applied for 9 days.

Results Follow up MR done 3 and 8 months after intervention, showed chronic left cerebral focal infarctions and complete exclusion of the aneurysm. Angiographic study done 11 months after intervention showed complete exclusion of the aneurysm.

Conclusion Endovascular treatment using flow diverter with additional coiling seems to be the first choice of treatment in selected patients with petrous segment carotid aneurysms.

Disclosure of Interest Nothing to disclose

P011/105

ABSTRACT WITHDRAWN