

were comparable between TPA and TNK groups. Access site complication rates were similar between groups (hematoma: TNK 2.7% vs TPA 3.2%, oozing: TNK 5.4% vs TPA 2.1%, pseudoaneurysm: TNK 1.8% vs TPA 1.1%, arterial occlusion: 0.9% vs 1.1%; unadjusted $p=0.795$). The adjusted odds ratio for hemorrhagic access site complications with TNK was 1.26 (95% CI 0.38 - 4.19, $p=0.708$). Access site complications did not correlate with 90-day functional outcomes or intracranial hemorrhage rates.

Conclusions Among stroke patients undergoing emergent endovascular treatment, hemorrhagic and non-hemorrhagic femoral access site complication rates were similar with TNK compared to TPA.

Disclosures P. Koul: None. V. Bohl: None. G. Badger: None. T. Bielinski: None. J. Pafumy: None. M. Collins: None. C. Schirmer: None. P. Hendrix: None.

E-255

DEVELOPING A STROKE THROMBECTOMY PROGRAM IN URBAN TANZANIA

¹S Nguyen*, ²F Sherif, ³S Matuja, ¹K Budohoski. ¹Department of Neurosurgery, University of Utah, Salt Lake City, UT; ²Department of Neurology, Texas Tech University Medical Center, El Paso, TX; ³Department of Internal Medicine, Neurology division, Catholic University of Health and Allied Sciences-Weill Bugando, Mwanza, Tanzania, United Republic of

10.1136/jnis-2024-SNIS.360

Background Stroke is a leading cause of morbidity and mortality globally with high social and economic burden. It has been shown that the majority of mortality and lost economic productivity impacts low- and middle-income countries (LMICs). (Barbosa; Saini) This has specifically been demonstrated in Dar es Salaam, Tanzania, as shown in a prospective cohort from 2016–17 where 149 patients with imaging-confirmed stroke demonstrated a 50% mortality at 90-days. (Regenhardt) Endovascular thrombectomy (EVT) is a cost-effective way to decrease morbidity and mortality associated with stroke in high-income countries. (Barbosa) However, this treatment not currently available in the majority of LMICs, likely contributing to the significantly higher mortality rate when compared with high-income areas. Given the high incidence of stroke and lack of available interventions we seek to establish a sustainable program of neuroendovascular intervention focusing on EVT in Dar es Salaam.

Methods The program was developed using 3 partially overlapping objectives: 1. Epidemiological study seeking to determine the epidemiology of acute ischemic stroke patients who would be eligible for EVT treatment; 2. Development of a consensus statement, based on the modified Delphi methodology, on the essential requirements for performing EVT; 3. Implementation of a sustainable teaching and training program for neuroendovascular intervention focusing on EVT in Dar es Salaam.

Results Acute ischemic stroke registry at Bugando Medical Center in Mwanza recruited 566 patients. 57.1% of patients were admitted with NIHSS ≥ 6 and 19.3% were admitted within 24 hours of symptom onset. 50.4% of patients were insured, however, CT angiography was not performed in the majority of patients. The registry has been expanded to include patients admitted to Muhimbili National Hospital in Dar es Salaam with mandated CT angiography in all patients who would qualify for EVT treatment. An international panel of 35 experts in stroke thrombectomy provided insights into

essential resources required to safely perform EVT in low-income settings. The first training session of neuroendovascular intervention was performed in November 2023 focusing on vascular anatomy, indications and cerebral angiography, with simulation sessions involving flow models of cerebral aneurysms and stroke.

Future Directions Epidemiological data together with cost-effectiveness data will be used to determine the eligible population of patients eligible for EVT for stroke. This data together with the Delphi consensus on essential requirements for safe EVT will be used to guide resource allocation within the public sector health care in urban Tanzania. Ultimately, we aim to develop a self-sustaining program of neuro-endovascular intervention which will be based on locally available data and resources.

Disclosures S. Nguyen: None. F. Sherif: None. S. Matuja: None. K. Budohoski: None.

E-256

IMPACT OF THE COVID-19 PANDEMIC ON TREATMENT TRENDS OF ANEURYSMAL SUBARACHNOID HEMORRHAGE

¹S Patel, ²A Balabhadra*, ³I Gandhi, ⁴F Otite, ⁵M Jaffa, ¹C Bruno, ⁶E Sussman, ¹M Ollenschleger, ⁵M Alberts, ¹T Mehta. ¹Department of Interventional Neuroradiology, Hartford Hospital, Hartford, CT; ²Department of Neurology, University of Connecticut, Farmington, CT; ³University of Connecticut, Storrs, CT; ⁴Department of Neurology, University of Connecticut, Syracuse, NY; ⁵Department of Neurology, Hartford Hospital, Hartford, CT; ⁶Department of Neurosurgery, Hartford Hospital, Hartford, CT

10.1136/jnis-2024-SNIS.361

Background We explore COVID-19's potential link to aneurysm evolution via hypercytokinemia and inflammation, analyzing its impact on ruptured aneurysmal subarachnoid hemorrhage (aSAH) trends and outcomes.

Methods We queried the 2016–2020 National Inpatient Sample (NIS) database for patients aged 18 years and above with aSAH. Patients were treated either surgically or endovascularly (EV) and were identified using ICD-10 codes. Using SAS software, we defined baseline demographics, hospital characteristics, and outcomes for two groups: pre-COVID (2016–2019) vs. COVID (2020). Weighted discharge data was used to generate national estimates.

Results We identified 55,340 patients admitted with aSAH who underwent treatment with either open surgical approach (n=14,445; 26.1%), EV approach (n=38,085; 68.8%) or combined (n=2,810; 5.1%). Median age was 56.4 years (surgical group 55.0 vs. EV group 56.7; $P>0.05$) with 37,550 (67.9%) being female. After adjusting for age and gender, there were no significant differences observed in inpatient mortality rates between the two treatment groups (surgical group- OR: 1.12; $p=0.39$ and EV group- OR:1.07; $p=0.41$) between pre-COVID vs. COVID epoch. During the COVID pandemic, 170 COVID+ patients underwent treatment (surgical group n=35/170 (20.6%) and EV group n=135/170 (79.4%)). Baseline characteristics between COVID+ vs. COVID- groups were age 48.5 vs. 56.4 ($p=0.011$), length of stay 19.0 vs. 15.5 ($p=0.028$), total hospital charges \$503,872 vs. \$341,657 ($P=0.0008$). The ratio of EV vs. open surgical approach was 2.6 from 2016–2020 for COVID-patients whereas a ratio of 4.7 was observed in COVID+ patients during 2020 ($p=0.004$).

Conclusion This nationwide study of the NIS demonstrated higher utilization of EV therapy compared to an open surgical