Case Description A 59-year-old woman presented to the emergency department complaining of headaches. Brain-CT revealed bilateral cavernous sinus thrombosis with purulent contents, along with stenosis of the cavernous and petrous portions of the left internal carotid artery due to infectious arteritis. Sudden onset of diplopia 15 days later prompted further MRI, which identified an infectious aneurysm in the petrous portion of the left internal carotid artery. A multidisciplinary decision was made to embolize the aneurysm once the septic condition was controlled through sterile blood cultures and effective antibiotic therapy. Endovascular treatment involved dual antiplatelet therapy and therapeutic anticoagulation, deploying a flow-diverter opposite the aneurysm sac followed by coil obliteration using the jailing technique, achieving satisfactory exclusion post-procedure. However, suspicion of hemorrhagic shock arose post-procedure. Emergency CT scan revealed a large sub- and retroperitoneal hematoma with active bleeding from the puncture sites of both common femoral arteries. Urgent arteriography of femoral arterial approaches failed to reveal active bleeding, subsiding after prolonged manual compression and compression dressing. At the two-year mark, satisfactory exclusion of the aneurysm persisted with no residual neurological deficit.

Results This case underscores the challenges in managing unruptured infectious intracranial aneurysms associated with cranial nerve palsy, particularly the placement of endovascular devices in a septic environment and managing associated complications.

Disclosure of Interest no.

P032 FUSIFORM ANUERYSM OF BASILAR ARTERY -AN ILLUSTRATIVE CASE

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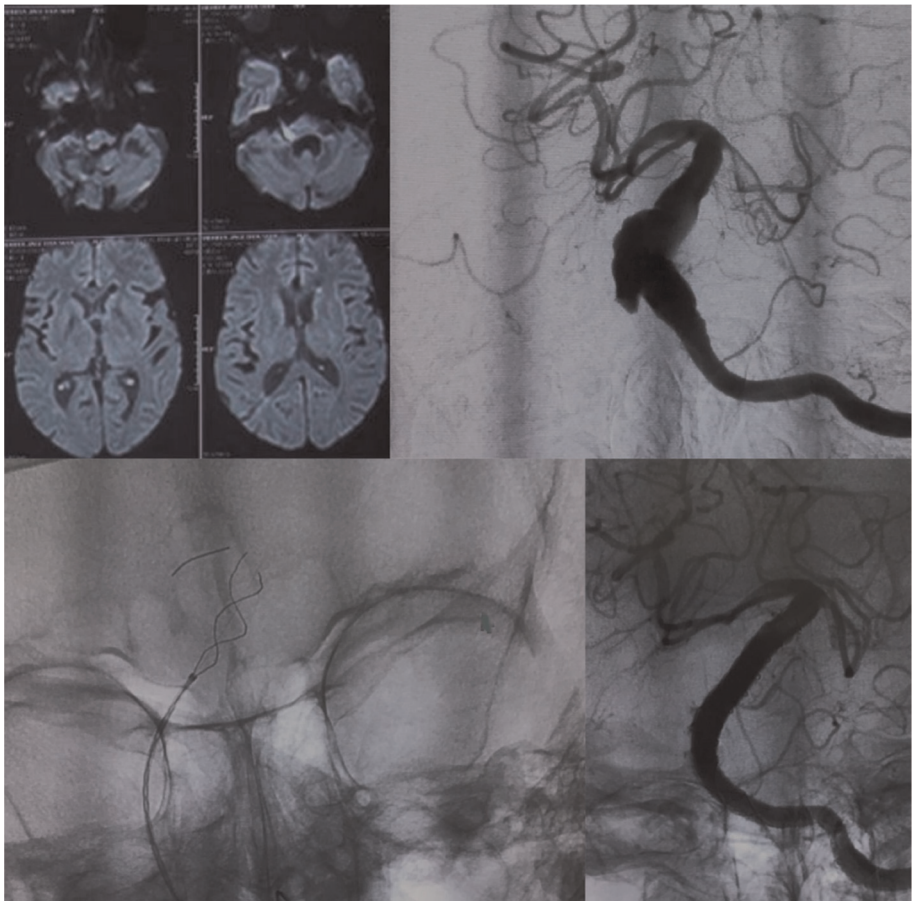
Introduction This case study aims to elucidate the procedural challenges and outcomes of endovascular treatment for a basilar artery fusiform aneurysm using a braided nitinol stent, highlighting the importance of meticulous technique and preoperative planning

Case Description A 56-year-old female presented with recurrent posterior circulation strokes attributed to a fusiform aneurysm involving the basilar artery, complicated by hypoplastic right vertebral artery and tortuous left vertebral artery. Endovascular intervention was pursued to mitigate the risk of further cerebrovascular events. Preoperatively, the patient received oral Brilinta and aspirin. Access was achieved via the right femoral artery, with navigation to the basilar artery using a 6 French DAC Fargomax catheter. Deployment of a LEO +



Abstract P032 Figure 1

0.45cm *75 mmbraided nitinol stent was performed via a VASCO + 25 MP microcatheter, with careful anchoring and expansion. Procedural adjustments were made to address flow occlusion encountered due to increased catheter caliber.

Results Despite technical challenges, successful stent deployment was achieved, and the Leo stent was detached without complications. Post-procedural and followup 3-month angiography revealed satisfactory stent positioning and flow restoration. Endovascular treatment of a basilar artery fusiform aneurysm using a braided nitinol stent demonstrated feasibility and efficacy, albeit with procedural intricacies. Meticulous technique, precise stent deployment, and preoperative antiplatelet therapy are crucial considerations for optimizing outcomes in such complex cerebrovascular interventions. This case underscores the importance of tailored approaches and careful procedural planning in managing challenging cerebrovascular pathologies.

Disclosure of Interest no.

Miscellaneous

P033 DOES A LARGE CENTRAL GYRAL DVA WORSEN PARESIS IN A PATIENT WITH HTLV-1 MYELOPATHY? A CASE REPORT

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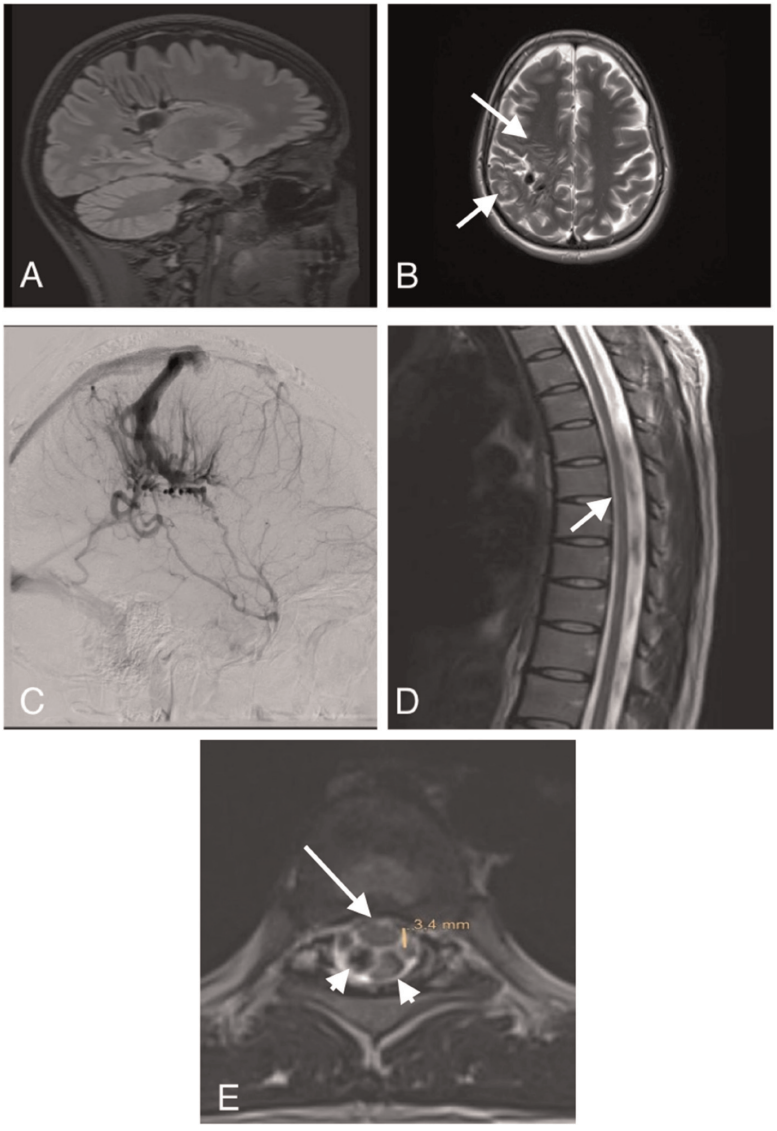
Introduction Developmental venous anomalies (DVAs) are prevalent congenital vascular malformations of the brain, often incidentally discovered in imaging studies with small veins



Abstract P033 Figure 1 Sagittal FLAIR (A) and lateral DSA in venous phase via right ICA-injection (C) showing the typical Medusa Head formation of the intracranial developmental venous anomaly. Axial T2-weighed sequences of the cranial MRI showing the characteristic medullary veins with gliotic changes to the surrounding brain parenchyma located in the right frontal and parietal white matter (white arrows in B). A sagittal (D) and axial (E) T2-weighted MRI scan of the spine showing the aforementioned myelon atrophy (white arrows in D, E). Note the flow voids of the CSF in the spinal T2-weighted images (white arrowheads in E)