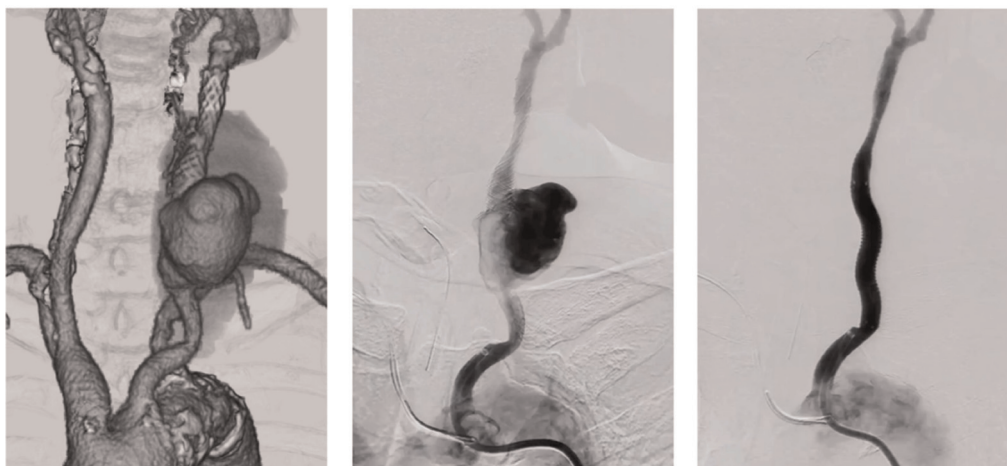


Abstract P043 Figure 3 Roadmap image in working projection showing successful catheterization of the outflow arterial segment of the aneurysm

vertebral artery with elongation and kinking and difficult catheterization of distal basilar artery segment

Treatment over 2 sessions. Initially failed transfemoral approach, followed by a successful transradial approach. Platelet suppression using Glycoprotein IIb/IIIa inhibitor. Catheterization of distal artery segment was achieved using a large s-shaped microguidewire configuration (figures 2-3). Application of Flowdiverter (4.5*40 mm) and coiling in jailing technique. Follow-up MRI examination showed minimal progress of brainstem edema and compression and post interventional cerebellar microemboli. Patient discharged 28 days later with no new symptoms (NIHSS 1, mRS: 2).

Results Treatment of giant vertebralbasilar aneurysms is challenging. Treatment within an interdisciplinary team and adequate prophylactic measures could avoid potential complications.



Abstract P044 Figure 1

Complications

P044 CAROTID BLOWOUT SYNDROME AS A LATE COMPLICATION AFTER CAROTID ARTERY STENTING FOR AN IRRADIATED NECK, SUCCESSFULLY TREATED WITH COVERED STENTS: AN ILLUSTRATIVE CASE

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Introduction Carotid blowout syndrome (CBS) is a potentially fatal disease requiring prompt intervention. Direct surgery is sometimes overly invasive, and patients are often intolerant for carotid artery occlusion. We present a case of impending CBS occurring two months after carotid artery stenting (CAS) for an irradiated neck, successfully treated with covered stents.

Case Description An 85-year-old man, with a permanent tracheal fistula following radiotherapy for pharyngeal cancer, presented with symptomatic stenosis of the left common carotid artery (CCA), necessitating CAS. Two months after CAS, he presented with a pulsatile mass at the left neck, oozing to the surface. Computed tomography angiography revealed a CCA pseudoaneurysm, indicating impending CBS. Due to the short distance between the CCA orifice and the aneurysm, we applied the 'no-touch' technique, using a 4-Fr Newton-shaped stiff catheter (Newton-T, Medikit, Tokyo, Japan), during the guiding catheter navigation and secured the guiding catheter with snare, facilitating a stable procedure. Two self-expanding covered stents (GORE VIABAHN, Gore, Flagstaff, AZ, USA) were deployed to cover the ruptured site.

Results The patient experienced no neurological complications through the course. After recovery from infections, he transferred to a rehabilitation facility for disuse syndrome on Day 45, and underwent skin flap surgery for the skin defect due to the subcutaneous hematoma on Day 71.

When patients are not tolerated for carotid artery occlusion, reconstruction with covered stents emerges as an effective alternative for treating CBS. The success of this approach hinges upon the safe navigation and stabilization of the guiding catheter.

Disclosure of Interest no.