

angiographic intraoperative images which identified a capillary blush in the choroid plexus (figure 2).

Consequently, a further assessment was conducted using a dual-energy CT scanner: findings were initially confirmed in the basal CT images, but disappeared when the iodine map was applied, thus ruling out the suspected SAH (figure 3).

**Results** We hypothesized that observed hyperdensity was likely due to the accumulation of contrast medium in the choroid plexuses at the roof and lateral recesses of the fourth ventricle. This finding was probably exacerbated by local arterial spasm, which may have determined greater diversion of contrast towards choroidal plexus branches. The hyperdensity was no longer visible in the 24-hour follow-up CT scan. Throughout the procedure and subsequent observations, the patient maintained normal neurological function.

Dual-energy CT employing iodine map reconstructions could be crucial in early discrimination between blood and contrast medium accumulation in the fourth ventricle, following intra-arterial procedures.

## Miscellaneous

### P046 VENOUS SINUS STENTING WITH HIPOINT 088 CATHETER EXTENDER AND TENZING 8

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**Introduction** Stenting is increasingly performed for venous sinus stenosis associated with refractory pseudotumor cerebri and pulsatile tinnitus (PT). The Monopoint access system (Route 92 Medical, San Mateo, CA) is a triaxial telescoping system of catheters with simplified points of control outside the body, consisting of: 0.106" Base Camp guide catheter, 0.088 inch ID catheter on a wire (HiPoint 88) and delivery catheter (Tenzing 8). The system may be well suited to venous sinus stenting (VSS).

**Case Description** A female in her mid-40s presented with pressure headaches, visual obscurations, papilledema with field cut, and PT. MRI revealed bilateral transverse sinus stenoses. Attempted medical therapies (Diamox, weight loss) had failed to improve her condition. DSA showed a dominant right transverse sinus stenosis with a 15 mmHg pressure gradient.

VSS was performed. After 9 F femoral venous access, a Basecamp was placed in the right jugular bulb. The right transverse sinus stenosis was crossed, first with a leading 0.014 inch microwire with a 'J' shaped tip, followed by Tenzing 8, followed by HiPoint 88, without difficulty. After Tenzing removal, a Zilver 518 8 x 40 mm stent (Cook, Bloomington, IN) was advanced to the target within the HiPoint 88 (figure 1A) and unsheathed by pulling back the HiPoint wire (figure 1B, black arrow). The stent was deployed. No residual stenosis or complications were observed. She was discharged on a 6-months of dual antiplatelets.

**Results** At 8 month clinical follow up, her headaches, vision, papilledema and PT had improved, with wide stent patency on MRI head.

**Disclosure of Interest** yes Fabio Settecase: consultant and equity interest Route 92 Medical.

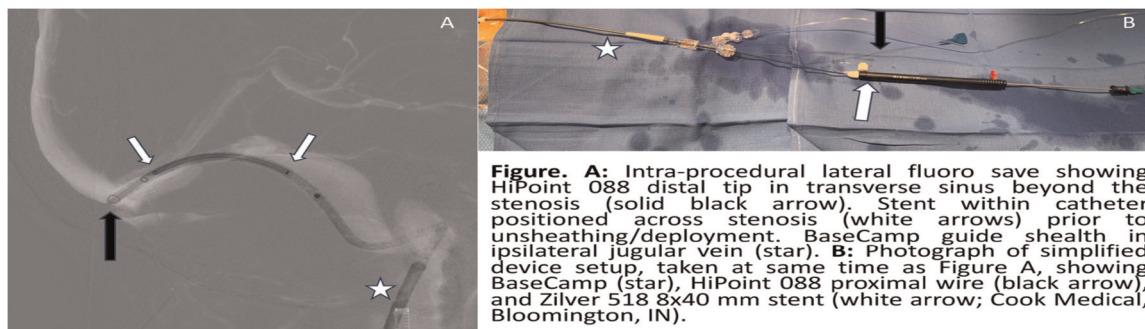
### P047 A CASE REPORT- THE USE OF PK PAPYRUS COVERED STENT FOR TRAUMATIC DIRECT CAROTID CAVERNOUS FISTULA

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**Introduction** A Direct Carotid Cavernous Fistula is an abnormal shunt between the internal carotid artery and the cavernous sinus. Covered stents are usually not used for neurointerventional procedures due to concerns of occlusion of perforating vessels and being thrombogenic. We present a case demonstrating safety and efficacy of a covered stent in a direct Carotid Cavernous Fistula.

**Case Description** A 57yrs old man was involved in an accident, sustained a direct left eye injury. He developed a Carotid cavernous fistula one day after the accident which was confirmed on computed tomography angiography. We performed endovascular treatment by implanting a covered stent (Papyrus 4x15mm) in the cavernous segment of internal carotid artery covering the fistulous point with use of 6F guided catheter and no intermediate catheter. During the procedure, half a vial of IV Aspirin and IV Tirofiban were administered according to the protocol.



**Figure. A:** Intra-procedural lateral fluoro save showing HiPoint 088 distal tip in transverse sinus beyond the stenosis (solid black arrow). Stent within catheter positioned across stenosis (white arrows) prior to unsheathing/deployment. BaseCamp guide sheath in ipsilateral jugular vein (star). **B:** Photograph of simplified device setup, taken at same time as Figure A, showing BaseCamp (star), HiPoint 088 proximal wire (black arrow), and Zilver 518 8x40 mm stent (white arrow; Cook Medical, Bloomington, IN).

### Abstract P046 Figure 1