

Abstract E-100 Table 1

	Number (%)
Total cases	40
Total patients	36
Age (years)	59.9 ± 11.0
Male	7 (17.5%)
Total aneurysms treated	44
Aneurysm size	7.2 mm
Anterior circulation	41 (93.2%)
Cavernous	6 (14.6)
Clinoidal	3 (7.3)
Ophthalmic	14 (34.1)
Communicating	12 (29.3)
Anterior communicating	5 (12.2)
Distal ACA	1 (2.3)
Posterior circulation	3 (6.8)
PICA	1 (2.3)
Vertebral	2 (4.5)
Triaxial system	40
Guide sheath	
NeuronMax	32 (80)
Select catheter	
JB-1	34 (85)
Guide catheter	
Catalyst 0.058	36 (90)
Navien 0.058	8 (20)
Microcatheter	
Via 0.027 inch	40 (100)
Marksman	3 (7.5)
Pipeline embolization devices	48
Cervical tortuosity	10 (25%)
Guide catheter position	
ACA	4 (10)
MCA	32 (80)
Supraclinoidal ICA	1 (2.5)
Basilar	2 (5)
Vertebral	1 (2.5)
Clinical success	
VIA tracked to target	40 (100)
Successful resheathing	6/6 (100%)
Successful treatment	40 (100)

The VIA27 (Sequential) is an alternative 0.027" microcatheter originally designed for intrasaccular flow diverter delivery. Here we describe our experience with the VIA27 in the delivery of PEDs.

Methods We retrospectively identified patients who underwent PED treatment with the VIA27 microcatheter at our institution. Patient demographics, equipment utilized, intraprocedural catheter positions and periprocedural complications were documented.

Results 36 patients underwent 40 embolizations of 44 aneurysms with 48 PEDs (Table 1) using the VIA27. The average age was 59.9 ± 11.0 years; 7 (17.5%) were male. Most aneurysms 41 (93.2%) were located anteriorly. The average aneurysm size was 7.2 mm with 38 (86.4%) small, 3 (6.82%) large, and 3 (6.82%) giant. The VIA27 was successfully used to deploy all 48 PEDs (Figure 1). 6 attempts were made to resheath the PED during placement; all were successful. The distal tip of the catheter was located in the ACA 4 (10%),

MCA 32 (80%), supraclinoidal ICA 1 (2.5%), basilar 2 (5%), and distal vertebral 1 (2.5). In 3 (7.5%) cases where the VIA27 catheter was unable to track, alternate catheters were used to advance and then exchanged back to the VIA27. In 3 (7.5%) instances, the Marksman was unable to provide adequate push for PED deployment; the VIA27 was exchanged for placement of the PED. No patients experienced iatrogenic vessel injury or other microcatheter associated complications.

Conclusions The VIA27 is capable of safe FlexPED delivery in the treatment of intracranial aneurysms. We have shown its utility in enhancing both resheathing and push for optimal FlexPED placement. The 0.027" VIA may be a useful and safe adjunct to the more traditional Marksman in FlexPED treatments of cerebral aneurysms.

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E-101 INITIAL RESULTS FROM EFFECTIVE ZONE FOR MOBILE STROKE TEAM TRIAL

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Introduction In Japan, endovascular treatment for acute ischemic stroke from large vessel occlusion should be performed by neurointerventionists. However, most hospitals in Hokkaido, a Northern island of Japan, that offer treatment for cerebral vascular disease do not have access to a neurointerventionist; the rural areas are especially affected. Thus, Hokkaido University has offered support to institutions without a neurointerventionist, to perform endovascular treatment.

The neurointerventionists stationed in other hospitals drive to retrieve the resultant clot since the acute ischemic stroke from large vessel occlusion. We called this the "drive and retrieve system" method, and launched the effective zone for mobile stroke team (EZO) trial to evaluate the validity and efficacy of this method.

Herein, we report the initial results of the EZO trial.

Methods Nine institutes across our affiliated hospitals within a one-hour drive from Sapporo City took part in this trial.

Three of these 9 institutes that have a full-time neurointerventionist were registered as the source. When an episode of acute ischemic stroke requiring intervention occurred in the other 6 hospitals, the available neurointerventionist provided treatment based on the drive and retrieve method. The neurointerventionists' schedules was updated and distributed to all participating units twice a week, so that the supported hospitals could immediately make contact when required. We analysis the data of 21 cases in the EZO trial from July 2015 to October 2015.

Results For 19 out of 21 cases (90%), endovascular treatment could be performed endovascular immediately. The median time from door- to- puncture was 18 min (interquartile range [IQR]: 49.25–91.5). The median time from puncture to arrival of the neurointerventionist was also 18 minute (IQR: 3.5–30.5). The recanalization rate (TICI 2 b/3) was 81 %.

Conclusion The drive and retrieve system has the potential to support rural medical institutes that do not have access to a full-time neurointerventionist.

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