

more than 50% decreased size of 4 of 9 cases (44.4%) and less than 50% decreased size in 5 of 9 cases (55.5%). **Conclusion:** Endovascular embolization of cerebral AVMs by transfemoral artery approach using microcatheter navigation and embolization has some technical difficulties with success rate for navigation and embolization (64%). It is an effective treatment method to control hemorrhagic cerebral AVMs, to decrease associated seizures, and to decrease the size of cerebral AVMs.

P305

Mechanical Thrombectomy in Acute Stroke: A Single-Center Cohort Study

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Objectives: The study purpose is to evaluate the clinical outcomes of mechanical thrombectomy in acute stroke management regardless the administration of intravenous or intra-arterial tissue plasminogen activator. **Methods:** We retrospectively reviewed medical records of the patients from 2014 to 2019 at our single center in Dubai, UAE. A total of 150 patients who underwent mechanical thrombectomy for acute ischemic stroke were identified. The mechanical thrombectomy was performed within 6 h after the onset of stroke symptoms. Both stent retriever and/or thrombus aspiration techniques were used. Patients who have been treated with or without intravenous or intra-arterial alteplase were included also. All patients were confirmed to have proximal anterior circulation occlusion. Patients with large infarct on neuroimaging (ASPECT score 6 or more) were excluded from the study. The primary endpoint was to assess the severity of clinical disability at 72 h and at the time of discharge using the National Institutes of Health Stroke Scale score and modified Rankin scale. **Results:** This is an ongoing study with preliminary results showing that mechanical thrombectomy reduced the severity of disability over the range of the National Institutes of Health Stroke Scale score and modified Rankin scale. **Conclusion:** Mechanical thrombectomy has reduced the severity of poststroke disability and increased the rate of functional independence.

P306

Complication or Neurovascular Interventions and How to Treat Them

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Educational Poster Background: Recent studies have reported a high prevalence of cerebral vascular malformations in the general population; further, stroke is the fifth leading cause of death in the United States. Endovascular therapies are used with increasing frequency for the treatment of these patients. For this, it is fundamental to consider the complications that can be seen after endovascular interventional modalities. As the number of endovascular interventions increases, periprocedural complications

become more common. These complications can be serious and often lead to prolong stays in the intensive care units, delay rehabilitation, and increase morbidity. This main complications are:

- Subarachnoid hemorrhage is a common complication, usually caused by rupture treated vessel
- Distal embolization of occluded plaque, new emboli in another location, and vasospasm or reocclusion
- Intracranial artery dissection
- Arteriovenous fistula results from a direct vessel perforation.
- Puncture site complications, such as pseudoaneurysm, hematoma, or dissection.
- Migration of the embolization material distal or to systemic circulation.

The treatment with endovascular procedures is used more and more frequently, and in some instances, it is the only option available for certain situations. That is why it is important to know the fundamental elements about these procedures as well as the complications that these entail and, above all, how to treat them using the different image tools.

1. To describe basic concepts of the different neuroendovascular procedures and how to evaluate their results by image.
2. To evaluate the most common complications after neuroendovascular interventional treatments and discuss these findings describing diagnosis keys.

P401

Fluoroscopic-Guided Self-Expandable Retrievable Esophageal Stent Application in the Management of Postbariatric Surgery Anastomotic Leaks

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Objectives: Anastomotic leakage is a major complication of bariatric surgeries that can lead to high mortality and morbidity. Depending on the clinical presentation, management options include conservative management with or without external drainage, stenting, or surgical re-intervention which carries relatively high morbidity and mortality rates. **Methods:** Self-expanding silicon stents were inserted under fluoroscopic guidance in 16 patients with radiologically diagnosed anastomotic leakage; nine of them postbariatric gastric bypass operation and seven patients after laparoscopic sleeve. Patients were referred for stenting between 7 and 26 days (mean 14 days) after surgery. Balloon repositioning was needed twice in one patient distal migration. The stent was left for 8 weeks in all patients. The patients were following a strictly fluid diet to avoid stent migration. Stents were removed endoscopically. All patients were followed till removal of the stents. **Results:** A 100% technical success was achieved defined as successful positioning of the stent bypassing the leakage. Distal migration occurred twice in the same patient with balloon repositioning. Persistence of the leakage after stent removal took place in seven patients (all