

P.114**Flow diversion of bifurcation aneurysms is more effective when the jailed branch is occluded: an experimental study in a novel canine model**

T Darsaut (Edmonton) R Fahed (Paris) G Gevry (Montreal) J Genetic (Brest) I Salazkin (Montreal) J Raymond (Montreal)*

doi: 10.1017/cjn.2016.215

Background: Flow diverters (FDs) are increasingly used for bifurcation aneurysms. Failure of aneurysm occlusion may be caused by residual flow maintaining patency of the jailed branch along with the aneurysm. **Methods:** Sixteen wide-necked lingual-carotid artery bifurcation aneurysms were created in 8 canines. Patent aneurysms were randomly allocated 4 weeks later to flow diversion combined with jailed branch occlusion using coils and/or Onyx (n=6) or flow diversion alone (n=8). Angiographic results of aneurysm occlusion at three months were scored using an ordinal scale. Pathology specimens were photographed and neointimal coverage estimated. **Results:** Fourteen aneurysms were patent at one month. FD deployment was successful in all cases, but at 3 month follow-up, 3 devices had prolapsed into the aneurysm. None of the bifurcation aneurysms treated with FD alone were occluded at 3 months. Endovascular branch occlusion combined with flow diversion significantly improved aneurysm occlusion rates (median angiographic score of 2) compared to flow diversion alone (median score of 0: P=0.0137). Flow-limiting parent vessel stenosis was not observed in any arteries. Devices were covered with thick neointima in most cases. **Conclusions:** Treatment failures following flow diversion of bifurcation aneurysms can be caused by persistent flow to the jailed branch. Branch occlusion combined with flow diversion may improve angiographic occlusion of canine aneurysms.

P.117**Delayed contralateral presentation of a carotid cavernous fistula following trauma**

S Husak (Saskatoon) R Ko (Saskatoon) M Kelly (Saskatoon)*

doi: 10.1017/cjn.2016.216

Background: We present a rare case of a left-sided carotid cavernous fistula (CCF) that presented 15 months post initial trauma with right-sided ophthalmic signs and symptoms. Highlighted is a contralateral endovascular approach to treating this traumatic CCF. **Methods:** Described is a case of a left-sided CCF caused by a self-inflicted gun shot wound to the head that was initially treated conservatively by neurosurgery and ophthalmology. The patient presented 15 months later with headache, acute right-sided periorbital swelling, severe right eye and facial pain. **Results:** Angiography confirmed the presence of a left-sided CCF with preferential drainage into the right cavernous sinus and right superior ophthalmic vein. The left internal carotid artery (ICA) was shown to be narrow and irregular. Multiple attempts to navigate the micro catheter through the vessel were unsuccessful. Instead, the fistula was embolized using a contralateral approach through the right internal carotid artery and across the anterior communicating artery. Imaging post-operatively confirmed successful occlusion of the CCF. **Conclusions:** This case is a rare example of a left-sided ICA occlusion secondary to trauma presenting 15 months after the initial injury with right-sided ophthalmic signs

and symptoms. It is also one of only a few in the literature that describe successful treatment of traumatic CCF through a contralateral approach.

P.118**An experience with combined cerebral oximetry and stump pressure measurement to guide shunt insertion during carotid endarterectomy**

R Kesarwani (Edmonton) M Findlay (Edmonton)*

doi: 10.1017/cjn.2016.217

Background: Cross-clamp ischemia during carotid endarterectomy (CEA) can cause perioperative stroke. Selectively shunting patients based on intraoperative monitoring modalities that assess risk for ischemia can reduce the occurrence of immediate stroke. An experience with combined cerebral oximetry and stump pressure measurement to direct selective shunting is presented here. **Methods:** Study comparing intraoperative monitoring data, the decision to shunt, and presence of immediate post-operative deficits. Patients were shunted if either cerebral oxygen saturation dropped by more than 10% by cerebral oximetry, or stump pressure during cross-clamping was less than 40 mmHg. Cross-clamp ischemia was determined by the presence of ipsilateral neurological deficit upon awakening. **Results:** 245 patients were included in this study. 22% were shunted. Patients who were not shunted were significantly more likely to have collateral blood flow detected on angiography. Immediate post-operative stroke was not encountered in any of the patients included in the study. One patient who met shunting criteria but was excluded since he could not have a shunt inserted due to difficult anatomy did suffer stroke. **Conclusions:** With the dual-monitoring criteria presented here, 22% of patients were shunted. With the exception of one patient who could not have a shunt placed, no immediate post-operative stroke was encountered.

P.119**Minimally invasive surgical disconnection of a spinal dural arteriovenous fistula with the use of intraoperative digital subtraction angiography**

MD Staudt (London) B Wang (London)* SP Lownie (London)*

doi: 10.1017/cjn.2016.218

Background: Spinal dural arteriovenous fistulas (dAVF) are a significant but treatable cause of progressive myelopathy. The goal of treatment is disconnection of the fistula, which is often accomplished through an open surgical approach. We report two cases using a minimally invasive surgical (MIS) approach for dAVF ligation with intraoperative digital subtraction angiography (DSA) to confirm occlusion. **Methods:** Case report. **Results:** Two patients presented with progressive thoracic myelopathy and were identified to have fistulous connections at the left L1 and T8 levels respectively. Intraoperatively, a left femoral puncture was performed and a 5-French (40 cm) sheath was inserted. Patients were positioned prone and intraoperative spinal DSA was performed using the Siemens Zeego. Once the feeding radicular artery was visualized, image overlay and cross-hair laser was used to trace and localize the fistulous zone. A unilateral single level MIS hemi-laminectomy was performed. The fistulous zone and accompanying nerve root were exposed and small