748 patients undergoing CTA for blunt cervical trauma, assaults, and strangulation (2013–2023) was conducted. After exclusions, 344 CTA reports were analyzed. Inclusion criteria: patients ≥18 years with complete medical records who underwent CTA for trauma evaluation. Exclusions: penetrating injuries, preexisting cerebrovascular abnormalities, incomplete records, or CTA not performed. Results: BCVI was identified in 38/344 cases (11%), with 55% classified as Grade I (Biffl). Posterior circulation (71%) and internal carotid arteries (36.8%) were most affected. Eight BCVI cases (21%) did not meet EDC; MVCs accounted for seven. MVCs (68%) and falls (29%) were the leading causes, while no BCVIs were observed in assaults or strangulations. Conclusions: MVCs and high-impact falls pose the highest BCVI risk, warranting CTA beyond EDC indications. In contrast, CTA may be less necessary for assaults and strangulations. Further studies across trauma centers are needed to confirm these findings.

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Isolated intraventricular hemorrhage presenting as reversible cerebral vasoconstriction syndrome

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doi: 10.1017/cjn.2025.10278

Background: Reversible cerebral vasoconstriction syndrome (RCVS) is defined clinically by headaches associated sometimes with seizures and neurological deficits, and radiologically with intermittent spasms in cerebral arteries that would resolve in 3 months. It can present with multiple bleeding patterns. Intraventricular hemorrhage (IVH) is a rare presentation for RCVS as there are 4 reported cases. Methods: This is a case report and review of literature. Results: A 36-year-old patient sought medical attention due to the acute onset of thunderclap headache. A computed tomography (CT), and CT angiogram (CTA) of his head and neck were done. It showed large IVH associated with hydrocephalus and no underlying vascular abnormalities. An external ventricular drain was placed and he was on nimodipine. A CTA was done on day 17 because he had acute global aphasia, right hemibody weakness, and right homonomous hemianopia, which showed severe diffuse intracranial stenosis involving the circle of Willis. He was taken to the angiography suite for chemical spasmolysis with verapamil. There was radiographic improvement and clinical resolution. Conclusions: This case highlights the rarity of RCVS presentations and further signifies the utility of intraarterial spasmolytics as an adjunct in the diagnosis of difficult cases. Further retrospective and prospective data are needed.

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Evaluation of endovascular access complexity on stroke patient's initial imaging: an agreement study

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doi: 10.1017/cjn.2025.10279

Background: Neck vessel imaging is often performed in hyperacute stroke to allow neurointerventionalists to estimate access complexity. This study aimed to assess clinician agreement on catheterization strategies based on imaging in these scenarios. Methods: An electronic portfolio of 60 patients with acute ischemic stroke was sent to 53 clinicians. Respondents were asked: (1) the difficulty of catheterization through femoral access with a regular Vertebral catheter, (2) whether to use a Simmons or reverse-curve catheter initially, and (3) whether to consider an alternative access site. Agreement was assessed using Fleiss' Kappa statistics. Results: Twenty-two respondents (7 neurologists, 15 neuroradiologists) completed the survey. Overall there was slight interrater agreement (κ=0.17, 95% CI: 0.10–0.25). Clinicians with >50 cases annually had better agreement (κ=0.22) for all questions than those with fewer cases (κ=0.07). Agreement did not significantly differ by imaging modality: CTA (κ=0.18) and MRA (κ=0.14). In 40/59 cases (67.80%), at least 25% of clinicians disagreed on whether to use a Simmons or reverse-curve catheter initially. Conclusions: Agreement on catheterization strategies remains fair at best. Our results suggest that visual assessment of pre-procedural vessels imaging is not reliable for the estimation of endovascular access complexity.

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Carotid artery coil extrusion: a rare but potential complication of endovascular coiling in post radiated neck

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doi: 10.1017/cjn.2025.10280

Background: Endovascular coiling is a minimally invasive technique for managing carotid blowout in head and neck

https://doi.org/10.1017/cjn.2025.10279 Published online by Cambridge University Press