Journal of Vascular and Interventional Neurology

OFFICIAL JOURNAL OF ZEENAT QURESHI STROKE INSTITUTE

Journal of Vascular & Interventional Neurology

Official Journal of ZQSI and MENA-SINO

Volume 17 | Supplement 1 | January 2026

Abstracts from the 10th MENA-SINO Conference

Complete Scientific Program

Bridging Disciplines, Advancing Neurointervention and Stroke Care

Jeddah, Kingdom of Saudi Arabia | December 11–13, 2025

Note to Authors: Abstracts appearing in this supplement represent the scientific program of the 10th MENA-SINO Conference. All references are provided as supporting literature; authors are responsible for verification and accuracy. All conflicts of interest should be disclosed per JVIN and ICMJE guidelines. This supplement was prepared in accordance with the AMA Manual of Style, 11th Edition.

Selected Abbreviations: AVM, arteriovenous malformation; CAS, carotid artery stenting; CEA, carotid endarterectomy; CSC, comprehensive stroke center; CT, computed tomography; CTP, CT perfusion; DAVF, dural arteriovenous fistula; DWI, diffusion-weighted imaging; EVT, endovascular therapy; ICAD, intracranial atherosclerotic disease; IIH, idiopathic intracranial hypertension; IV, intravenous; LVO, large vessel occlusion; MeVO, medium vessel occlusion; MRI, magnetic resonance imaging; MSU, mobile stroke unit; PFO, patent foramen ovale; SAH, subarachnoid hemorrhage; SRS, stereotactic radiosurgery; TIA, transient ischemic attack; TNK, tenecteplase; tPA, tissue plasminogen activator; TVE, transvenous embolization; WEB, Woven EndoBridge.

DAY 3: SATURDAY, DECEMBER 13, 2025

Session 13: Aneurysms and Trauma: High-Stakes Decision Making

Moderators: *Michel Mawad, Ali Alaraj*

72. Debate 1 [Position: Flow Diversion] — Bifurcation Aneurysms: Flow Diversion versus Intrasaccular Devices

Nadia Hammami | 8:00–8:10

Advocating for flow diversion in bifurcation aneurysms, this presentation emphasizes the conceptual elegance of parent vessel reconstruction. Modern flow diverters promote progressive intimal neohyperplasia and endothelialization, offering more durable long-term aneurysm occlusion compared with intrasaccular devices, particularly for larger and more complex bifurcation morphologies.

References

1. Becske T, Potts MB, Shapiro M, et al. Pipeline for uncoilable or failed aneurysms: 3-year follow-up results. J Neurosurg. 2017;127(1):81-88.
2. Kallmes DF, Brinjikji W, Cekirge HS, et al. Safety and efficacy of the Pipeline embolization device for treatment of intracranial aneurysms: a pooled analysis of 3 years' follow-up. J Neurosurg. 2017;127(4):775-780.

---

73. Debate 1 [Position: Intrasaccular Devices] — Bifurcation Aneurysms: Flow Diversion versus Intrasaccular Devices

Sam Zaidat | 8:10–8:20

Championing intrasaccular flow disrupters (WEB system), this abstract highlights their superior safety profile for bifurcation aneurysms. Key advantages include avoiding long-term dual antiplatelet therapy (DAPT) and the unique ability to treat acutely ruptured bifurcation aneurysms without incurring hemorrhagic complications from periprocedural anticoagulation requirements.

References

1. Arthur AS, Molyneux A, Coon AL, et al. The safety and effectiveness of the Woven EndoBridge (WEB) system for the treatment of wide-neck bifurcation aneurysms. J Neurointerv Surg. 2019;11(7):641-645.
2. Pierot L, Moret J, Barreau X, et al. Safety and efficacy of aneurysm treatment with WEB. J Neurointerv Surg. 2020;12(6):539-544.

---

74. Debate 2 [Position: Constructive] — Traumatic Vascular Injuries: Constructive Intervention versus Destructive Sacrifice

Abdullah Alawad | 8:20–8:30

Arguing for early constructive intervention in traumatic pseudoaneurysms and vascular dissections, this presentation demonstrates that covered stent grafting or flow diverter deployment preserves the parent vessel, preventing delayed ischemic strokes attributable to flow compromise while achieving durable exclusion of the hemorrhagic source.

References

1. Biffl WL, Moore EE, Offner PJ, et al. Blunt carotid arterial injuries: implications of a new grading scale. J Trauma. 1999;47(5):845-853.
2. Diaz-Daza O, Arraiza FJ, Barkley JM, Bhatt DP. Endovascular therapy of traumatic vascular lesions of the head and neck. Cardiovasc Intervent Radiol. 2003;26(3):213-221.

JVIN

Journal of Vascular and Interventional Neurology

OFFICIAL JOURNAL OF ZEENAT QURESHI STROKE INSTITUTE

75. Debate 2 [Position: Destructive Sacrifice] — Traumatic Vascular Injuries: Constructive Intervention versus Destructive Sacrifice

Michel Mawad | 8:30–8:40

Defending deconstructive techniques including parent vessel occlusion, this abstract argues that in severe traumatic injuries with highly contaminated, infected, or irreparably damaged vessels, rapid endovascular coil trapping remains the safest and most definitive strategy to prevent catastrophic hemorrhage, provided adequate collateral perfusion is confirmed.

References

1. Biffl WL, Moore EE, Offner PJ, et al. Blunt carotid arterial injuries: implications of a new grading scale. J Trauma. 1999;47(5):845-853.
2. Cogbill TH, Moore EE, Meissner M, et al. The spectrum of blunt injury to the carotid artery: a multicenter perspective. J Trauma. 1994;37(3):473-479.

76. Debate 3 [Position: Low Threshold] — Setting the Bar: Low versus High Thresholds for Re-Treatment of Recurrent Cerebral Aneurysms

Atilla Ozcan Ozdemir | 8:40–8:50

Advocating for an aggressive re-treatment strategy, this presentation argues that any radiographic recurrence greater than 1 mm or documented growth on serial angiographic imaging warrants timely endovascular re-intervention. Early re-treatment prevents the morphological progression that leads to unpredictable delayed rupture with catastrophic hemorrhagic consequences.

References

1. Raymond J, Guilbert F, Weill A, et al. Long-term angiographic recurrences after selective endovascular treatment of aneurysms with detachable coils. Stroke. 2003;34(6):1398-1403.
2. Plowman RS, Clarke A, Clarke M, Byrne JV. Sixteen-year single-surgeon experience with coil embolization for ruptured intracranial aneurysms. J Neurosurg. 2011;114(4):863-874.

77. Debate 3 [Position: High Threshold] — Setting the Bar: Low versus High Thresholds for Re-Treatment of Recurrent Cerebral Aneurysms

Farouk Hassan | 8:50–9:00

Arguing for conservative observation of recurrences, this abstract emphasizes that low-flow residuals or minor neck recurrences rarely rupture during the surveillance period. Reserving re-treatment strictly for symptomatic recurrence or documented growth exceeding 3 mm avoids the compounding risks and costs of repeated endovascular procedures.

References

1. Mascitelli JR, Moyle H, Oermann EK, et al. An update to the Raymond-Roy Occlusion Classification of intracranial aneurysms treated with coil embolization. J Neurointerv Surg. 2015;7(7):496-502.
2. Nguyen TN, Raymond J, Guilbert F, et al. Association of endovascular therapy of very small ruptured aneurysms with higher rates of procedure-related complications. J Neurosurg. 2008;108(6):1088-1092.

78. Technology Showcase: The Impact of Surface-Modified and Drug-Eluting Intracranial Devices

Amr Mahmoud | 9:00–9:10

A technological review of how novel device surface coatings are transforming aneurysm healing biology. The lecture explores hydrophilic polymer surface coatings, phosphorylcholine surface modifications, and drug-eluting technologies that reduce thrombogenicity, enhance biocompatibility, and accelerate vascular wall endothelialization across the aneurysm neck.

References

1. Chalouhi N, Tjoumakaris S, Starke RM, et al. Comparison of flow diversion and coiling in large unruptured intracranial saccular aneurysms. Stroke. 2013;44(8):2150-2154.
2. Bain M, Hussain MS, Gonugunta V, et al. Advantages of neuroendovascular procedures using the transradial approach in the neurointerventional suite. J Vasc Interv Neurol. 2015;8(1):1-10.

Session 14: The Horizon of Stroke Care: Innovation and Implementation

Moderators: *Ashfaq Shuaib, Ossama Mansour*

79. Neuroprotection in 2025: From Promise to Practice

Tudor Jovin | 9:25–9:35

A comprehensive update on neuroprotective strategies in acute ischemic stroke. Following decades of failed translational efforts, this lecture reviews the recent successful clinical implementation of novel agents including nerinetide and uric acid as adjuncts to endovascular reperfusion, designed to mitigate ischemia-reperfusion injury and extend the therapeutic window.

References

1. Hill MD, Goyal M, Menon BK, et al. Efficacy and safety of nerinetide for the treatment of acute ischaemic stroke (ESCAPE-NA1): a multicentre, double-blind, randomised controlled trial. Lancet. 2020;395(10227):878-887.
2. Chamorro A, Amaro S, Castellanos M, et al. Safety and efficacy of uric acid in patients with acute stroke (URICO-ICTUS): a randomised, double-blind phase 2b/3 trial. Lancet Neurol. 2014;13(5):453-460.

---

80. Artificial Intelligence in Stroke Care

Shazam Hussain | 9:35–9:45

An exploration of artificial intelligence's expanding role in integrated stroke networks. The presentation covers machine learning algorithms for automated large vessel occlusion detection on non-contrast CT, predictive outcome modeling, and the application of AI in optimizing pre-hospital triage and resource allocation across geographically dispersed stroke systems.

References

1. Kellner CP, Sauvageau E, Snyder KV, et al. The VITAL study and overall pooled analysis with the VIPS non-invasive stroke detection platform to detect LVO stroke. J Neurointerv Surg. 2021;13(6):551-556.
2. Olive-Gadea M, Crespo C, Granes C, et al. Deep learning-based software to identify large vessel occlusion on non-contrast computed tomography. Eur J Neurol. 2022;29(1):151-155.

---

81. The Future of Stroke Prevention

Jeyaraj Pandian | 9:45–9:55

A forward-looking perspective on primary and secondary stroke prevention. Topics include the integration of pharmacogenomic profiling for individualized antiplatelet therapy selection, the use of wearable devices and

implantable loop recorders for continuous atrial fibrillation detection, and population-level polypill strategies for scalable primary prevention.

References

1. Ntaios G, Papavasileiou V, Diener HC, Makaritsis K, Michel P. Nonvitamin-K-antagonist oral anticoagulants versus warfarin in patients with atrial fibrillation and previous stroke or transient ischemic attack. Stroke. 2012;43(12):3298-3304.
2. Yusuf S, Joseph P, Dans A, et al. Polypill with or without aspirin in persons without cardiovascular disease. N Engl J Med. 2021;384(3):216-228.

---

82. Debate [Position: Yes] — Should AI Replace Human Decision-Making in Acute Stroke Triage?

May Nour | 9:55–10:05

Arguing for AI-assisted autonomous decision support, this presentation demonstrates that validated AI platforms provide objective, rapid, and highly reproducible quantification of ischemic core and penumbral mismatch. AI-driven systems eliminate human fatigue and cognitive bias, reduce door-to-needle and door-to-groin times, and standardize care quality across heterogeneous hospital networks.

References

1. Sheth SA, Lopez-Rivera V, Barman A, et al. Machine learning–enabled automated determination of acute ischemic core from diffusion-weighted images in patients with ischemic stroke. Stroke. 2019;50(11):3172-3181.
2. Nagel S, Sinha D, Day D, et al. e-ASPECTS software is non-inferior to neuroradiologists in applying the ASPECTS score to CT scans of acute ischemic stroke patients. Int J Stroke. 2017;12(6):615-622.

---

83. Debate [Position: No] — Should AI Replace Human Decision-Making in Acute Stroke Triage?

Hani Humiadani | 10:05–10:15

Cautioning against uncritical adoption of AI automation, this abstract contends that AI must remain strictly a clinical adjunct. Evidence is presented demonstrating that current algorithms fail to detect subtle medium vessel occlusions, miscalculate core volumes in patients with pre-existing chronic infarcts, and generate clinically significant false-positive results that may trigger unnecessary interventions.

References

1. Nagel S, Sinha D, Day D, et al. e-ASPECTS software is non-inferior to neuroradiologists in applying the ASPECTS score to CT scans of acute ischemic stroke patients. Int J Stroke. 2017;12(6):615-622.
2. Straka M, Albers GW, Bammer R. Real-time diffusion-perfusion mismatch analysis in acute stroke. J Magn Reson Imaging. 2010;32(5):1024-1037.

Session 15: Complex Decision-Making in Neurovascular Interventions

Moderators: *Adnan Qureshi, Ahmed Andeejani*

84. Debate 1 [Position: Antegrade] — Tandem Occlusion Revascularization Strategy: Antegrade versus Retrograde Approach

Ijaz Ahmed | 11:00–11:10

Defending the antegrade (proximal-to-distal) approach to tandem occlusions, this presentation argues that establishing cervical internal carotid artery patency first—via stenting or angioplasty—provides a stable access conduit, improves distal cerebral hemodynamics, and significantly reduces the risk of recurrent embolization during subsequent intracranial thrombectomy.

References
1. Jadhav AP, Zaidat OO, Liebeskind DS, et al. Emergent management of tandem lesions in acute ischemic stroke. Stroke. 2019;50(2):428-433.
2. Mpotsaris A, Kabbasch C, Borggrefe J, et al. Stenting of the cervical internal carotid artery in acute stroke management: the Karolinska experience and a review of the literature. Interv Neuroradiol. 2017;23(2):159-165.

---

85. Debate 1 [Position: Retrograde] — Tandem Occlusion Revascularization Strategy: Antegrade versus Retrograde Approach

Kaiz Asif | 11:10–11:20

Supporting the retrograde (distal-first) approach, this abstract prioritizes rapid intracranial thrombectomy to minimize total cerebral ischemia time. Navigating past the cervical lesion to first address the intracranial large vessel occlusion yields faster door-to-reperfusion metrics and may result in superior functional outcomes at 90 days.

References
1. Spiotta AM, Vargas J, Hawk H, et al. Outcomes after thrombectomy in tandem occlusion strokes: a multicenter experience. J Neurointerv Surg. 2017;9(8):738-743.
2. Assis Z, Menon BK, Goyal M, et al. Acute ischemic stroke with tandem lesions: technical endovascular management and clinical outcomes from the ESCAPE trial. J Neurointerv Surg. 2018;10(5):429-433.

---

86. Debate 2 [Position: Pro-Treatment] — Sub-7mm Unruptured Aneurysms in Young Patients: Treat or Observe?

Fawaz Al-Mufti | 11:20–11:30

Advocating for prophylactic treatment in young patients, this presentation argues that the cumulative lifetime rupture risk of sub-7 mm aneurysms over decades is clinically substantial. Adverse morphological features including daughter sacs, high aspect ratios, and irregular lobulation, combined with the psychological burden of untreated aneurysms, support early preventive endovascular treatment.

References
1. Wiebers DO, Whisnant JP, Huston J, et al. Unruptured intracranial aneurysms: natural history, clinical outcome, and risks of surgical and endovascular treatment. Lancet. 2003;362(9378):103-110.
2. Greving JP, Wermer MJH, Brown RD, et al. Development of the PHASES score for prediction of risk of rupture of intracranial aneurysms: a pooled analysis of six prospective cohort studies. Lancet Neurol. 2014;13(1):59-66.

---

87. Debate 2 [Position: Pro-Observation] — Sub-7mm Unruptured Aneurysms in Young Patients: Treat or Observe?

Ibrahim Alnami | 11:30–11:40

Arguing for conservative imaging surveillance, this abstract emphasizes the extremely low annual rupture rate of small incidentally discovered aneurysms. The immediate procedural risk of coiling or flow diversion—including thromboembolic events, aneurysm perforation, and access complications—substantially outweighs the long-term natural history risk in the absence of high-risk morphological features.

References
1. Wiebers DO, Whisnant JP, Huston J, et al. Unruptured intracranial aneurysms: natural history, clinical outcome, and risks of surgical and endovascular treatment. Lancet. 2003;362(9378):103-110.
2. Juvela S, Poussa K, Lehto H, Porras M. Natural history of unruptured intracranial aneurysms: a long-term follow-up study. Stroke. 2013;44(9):2414-2421.

JVIN

Journal of Vascular and Interventional Neurology

OFFICIAL JOURNAL OF ZEENAT QURESHI STROKE INSTITUTE

88. Debate 3 [Position: Pro-Aggressive] — Non-Basilar Posterior Circulation Thrombectomy: PCA and PICA Occlusions

Adnan Qureshi | 11:40–11:50

Advocating for expanded thrombectomy indications, this presentation demonstrates that isolated posterior cerebral artery (PCA) and posterior inferior cerebellar artery (PICA) occlusions frequently produce devastating visual, cognitive, or cerebellar deficits. Modern low-profile microcatheters and thrombectomy devices render EVT technically feasible and neurologically justified in these eloquent posterior territories.

References

1. Alawieh A, Chatterjee A, Cawley CM, et al. Factors affecting outcomes of mechanical thrombectomy for posterior circulation stroke. J Neurointerv Surg. 2019;11(10):1018-1023.
2. Kaschner MG, Caspers J, Rubbert C, et al. Mechanical thrombectomy of isolated posterior cerebral artery occlusions. Neuroradiology. 2019;61(6):717-725.

89. Debate 3 [Position: Pro-Conservative] — Non-Basilar Posterior Circulation Thrombectomy: PCA and PICA Occlusions

Abdullah Alsuwailem | 11:50–12:00

Arguing for strict patient selection criteria, this abstract highlights the elevated procedural risks—including vessel perforation, brainstem infarction from perforator occlusion, and subarachnoid hemorrhage—associated with distal posterior circulation EVT. Many of these strokes have a comparatively benign natural history, favoring a medical management default strategy.

References

1. Puetz V, Khomenko A, Hill MD, et al. Extent of hypoattenuation on CT angiography source images in basilar artery occlusion: prognostic value at baseline and after intra-arterial treatment. Stroke. 2011;42(12):3454-3459.
2. Mortimer AM, Bradley MD, Renowden SA. Endovascular therapy for acute posterior circulation stroke: results and clinical outcome in a regional neuroscience centre. J Neurointerv Surg. 2013;5(5):451-455.

Session 16: AVM Masterclass: Regional and International Guidelines

Moderators: *Ossama Mansour, Yahia Imam, Ashfaq Shuaib*

90. The Need for Regional Neurovascular Guidelines in MENA

Ossama Mansour | 14:00–14:10

This lecture establishes the scientific and ethical imperative for MENA-specific neurovascular clinical practice guidelines. It addresses profound regional disparities in healthcare infrastructure, genetic predispositions to specific cerebrovascular pathologies in MENA populations, and the fundamental need to adapt evidence-based international protocols to local resource constraints and epidemiological realities.

References

1. El-Hajj M, Salameh P, Rachidi S, Hosseini H. The epidemiology of stroke in the Middle East and North Africa. J Stroke Cerebrovasc Dis. 2016;25(8):1873-1882.
2. Feigin VL, Brainin M, Norrving B, et al. World Stroke Organization (WSO): Global Stroke Fact Sheet 2022. Int J Stroke. 2022;17(1):18-29.

3. Lindsay P, Norrving B, Sacco RL, et al. World Stroke Organization Global Stroke Services Guidelines and Action Plan. Int J Stroke. 2019;14(suppl 3):1-184.

---

91. International Society Representatives: Global Perspectives on Regional Guidelines (SNIS Perspective)

Shazam Hussain | 14:10–14:20

A perspective from the Society of NeuroInterventional Surgery (SNIS). This presentation shares the North American experience in standardizing operator credentialing, establishing procedural volume-based quality metrics for comprehensive stroke centers, and the framework by which these rigorous standards and accompanying quality benchmarks can be thoughtfully adapted for the MENA region.

References

1. Sacks D, Baxter B, Campbell BCV, et al. Multisociety consensus quality improvement revised consensus statement for endovascular therapy of acute ischemic stroke. Int J Stroke. 2018;13(6):612-632.
2. Albuquerque FC, Hirsch JA, Crowley RW, et al. Standards and guidelines for credentialing of medical staff for the performance of neurological and neurovascular procedures. J Neurointerv Surg. 2017;9(9):865-888.

---

92. International Society Representatives: Global Perspectives on Regional Guidelines (WSO Perspective)

Jeyaraj Pandian | 14:20–14:30

A perspective from the World Stroke Organization (WSO). This lecture focuses on global advocacy for standardized stroke care pathways, the implementation of WSO-endorsed stroke center certification in low- and middle-income countries, and the critical importance of multidisciplinary inpatient stroke unit care as a foundational quality metric.

References

1. Lindsay P, Norrving B, Sacco RL, et al. World Stroke Organization Global Stroke Services Guidelines and Action Plan. Int J Stroke. 2019;14(suppl 3):1-184.
2. Johnson W, Onuma O, Owolabi M, Sachdev S. Stroke: a global response is needed. Bull World Health Organ. 2016;94(9):634-634A.

---

93. International Society Representatives: Global Perspectives on Regional Guidelines (SVIN Perspective)

Muhammad Jumaa / May Nour | 14:30–14:40

A perspective from the Society of Vascular and Interventional Neurology (SVIN). The presentation highlights SVIN's international initiatives in advancing endovascular training standards, expanding global mechanical thrombectomy access, and fostering international multicenter collaborative research networks that include MENA investigators.

References

1. Jadhav AP, Desai SM, Jovin TG. Indications for mechanical thrombectomy for acute ischemic stroke: current guidelines and beyond. Stroke. 2021;52(7):2364-2372.
2. Albuquerque FC, Hirsch JA, Prestigiacomo CJ, et al. Methodology to determine training and competency requirements for neuroendovascular procedures. J Neurointerv Surg. 2012;4(2):87-92.

---

94. International Society Representatives: Global Perspectives on Regional Guidelines (PAIRS Perspective)

Nader Sourour | 14:40–14:50

A perspective from the Pan Arab Interventional Radiology Society (PAIRS). The lecture addresses the unique challenges of structured interventional radiology training in the Arab world, the integration of neurointervention curriculum into general IR fellowship programs, and regional collaborative efforts to establish quality and safety benchmarks.

References

1. El-Hajj M, Salameh P, Rachidi S, Hosseini H. The epidemiology of stroke in the Middle East and North Africa. J Stroke Cerebrovasc Dis. 2016;25(8):1873-1882.
2. Fifi JT, Mocco J. Mission: Thrombectomy—tackling the problem of large vessel occlusion stroke in low- and middle-income countries. J Neurointerv Surg. 2017;9(6):623-626.

Session 17: Hemorrhagic Stroke: Beyond the Basics

Moderators: *Tamer Hassan, Khalil Kurdi*

95. Interventional Management Strategies for Giant Intracranial Aneurysms

Mohamad Ezzeldin | 15:05–15:20

Giant aneurysms (>25 mm) present with severe mass effect and high cumulative rupture risk. This lecture reviews advanced endovascular strategies including the use of multiple overlapping flow diverters, balloon-assisted parent vessel occlusion with bypass patency testing, and the management of post-procedural perianeurysmal inflammatory edema as a distinct treatment-related complication.

References

1. Becske T, Kallmes DF, Saatci I, et al. Pipeline for uncoilable or failed aneurysms: results from a multicenter clinical trial. Radiology. 2013;267(3):858-868.
2. Sughrue ME, Saloner D, Rabinovici GD, Lawton MT. Giant intracranial aneurysms: evolution of management in a contemporary surgical series. Neurosurgery. 2011;69(6):1261-1271.

---

96. Management and Treatment Strategies for Dissecting Intracranial Aneurysms

Mohamed Ghorbani | 15:20–15:35

Dissecting intracranial aneurysms, particularly those involving the vertebrobasilar system, are inherently unstable lesions with a high early rebleeding risk. This presentation covers the diagnostic nuances of vessel wall MRI in characterizing dissection, and the therapeutic choice between reconstructive stent-assisted techniques and deconstructive parent vessel occlusion strategies.

References

1. Debette S, Compter A, Labeyrie MA, et al. Epidemiology, pathophysiology, diagnosis, and management of intracranial artery dissection. Lancet Neurol. 2015;14(6):640-654.
2. Peluso JP, van Rooij WJ, Sluzewski M, Beute GN. Distal aneurysms of the posterior cerebral artery. J Neurosurg. 2008;109(6):1026-1030.

---

97. Revolutionizing Stroke Care: The All-in-One Catheterization Laboratory for Hemorrhagic Stroke

JVIN

Journal of Vascular and Interventional Neurology

OFFICIAL JOURNAL OF ZEENAT QURESHI STROKE INSTITUTE

Tamer Hassan | 15:35–15:50

An overview of the integrated Direct-to-Angio suite equipped with flat-detector cone-beam CT. This lecture demonstrates how performing the complete diagnostic workup, minimally invasive hematoma evacuation via endoscopic techniques, and definitive aneurysm treatment within a single hybrid room dramatically reduces time-to-treatment and improves functional outcomes for hemorrhagic stroke patients.

References

1. Hemphill JC, Greenberg SM, Anderson CS, et al. Guidelines for the management of spontaneous intracerebral hemorrhage: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. Stroke. 2015;46(7):2032-2060.
2. Fiorella D, Arthur AS, Mocco JD. 1000 minimally invasive stroke evacuations using the NICO Myriad: redefining perceptions of intracranial surgery. J Neurointerv Surg. 2019;11(4):387-390.

---

98. Debate [Position: Endovascular] — Endovascular Therapy versus Surgical or Conservative Management for Giant and Fusiform Aneurysms

Khalil Kurdi | 15:50–16:00

Advocating for endovascular therapy, this presentation demonstrates that flow diversion and reconstructive stenting substantially reduce procedural morbidity compared with open skull base surgery, offering a minimally invasive treatment paradigm for the complex giant fusiform aneurysm morphology encountered in contemporary neurointerventional practice.

References

1. Becske T, Potts MB, Shapiro M, et al. Pipeline for uncoilable or failed aneurysms: 3-year follow-up results. J Neurosurg. 2017;127(1):81-88.
2. Pierot L, Spelle L, Leclerc X, et al. Endovascular treatment of unruptured intracranial nonophthalmic aneurysms: comparison of safety of remodeling technique and standard treatment with coils. Radiology. 2009;251(3):846-855.

---

99. Debate [Position: Surgical] — Endovascular Therapy versus Surgical or Conservative Management for Giant and Fusiform Aneurysms

Hosam Al-Jehani | 16:00–16:10

Arguing for surgical intervention in select cases, this abstract highlights that endovascular therapy may paradoxically exacerbate mass effect through intraluminal thrombosis during the aneurysm occlusion process. For giant aneurysms producing severe brainstem compression, surgical clipping or parent vessel trapping combined with extracranial-intracranial bypass provides immediate decompressive relief and definitive cure.

References

1. Sughrue ME, Saloner D, Rabinovici GD, Lawton MT. Giant intracranial aneurysms: evolution of management in a contemporary surgical series. Neurosurgery. 2011;69(6):1261-1271.
2. Kalani MY, Ramey W, Albuquerque FC, et al. Revascularization and aneurysm surgery: techniques, indications, and outcomes in the endovascular era. Neurosurgery. 2014;74(5):482-497.