

follow up. Surprisingly, CVR as measured by CO_xa was statistically better in those recovering from TBI than in the healthy cohort. Conclusions: In the prospective cohort study, CVR as measured by NIRS based methods, was found to be more active in those recovering from TBI than in a healthy cohort. This study may indicate that, in those that survive TBI, CVR may be enhanced as a neuroprotective measure.

P.121

Subgaleal versus subdural drain after minicraniotomy for chronic subdural haematoma

*J Kam (Vancouver) S Li (Melbourne) B Ho (Melbourne)
R Akagami (Vancouver) A Rebchuk (Vancouver) J Wang
(Vancouver) A Farsakh (Melbourne)* L Lai (Melbourne)*

doi: 10.1017/cjn.2024.222

Background: Subdural and subgaleal drains are equally effective after burrhole craniotomy for chronic subdural haematoma, however the optimal location of drains after minicraniotomy is not clear. As such we present the first study to assess this. **Methods:** Consecutive patients undergoing minicraniotomy for cSDH between 2019 and 2023 at a single institution were included. Subgaleal drains were placed exclusively by a single surgeon with the rest of the department utilising standard subdural drains. Cases were stratified by drain location. Primary outcomes included changes in functional status (Modified Rankin Score, mRS) at 3 months from preoperative baseline. **Results:** A total of 137 patients were included, of which 24.6% received subgaleal drains. Discharge home was higher in the subgaleal group compared to subdural group (79.4% vs 57.3%, $p=0.02$). Subgaleal drain location ($p<0.0001$) and better preoperative GCS ($p=0.01$) were predictors of improved 3 month mRS. Worse pre-morbid mRS ($p=0.002$), subdural drain ($p=0.004$), and decreased consciousness at presentation ($p<0.002$) were predictors of not being discharged home. Surgical recurrence was lower in the subgaleal group than the subdural group (2.9% vs 13.6%, $p=0.12$), but not statistically significant. **Conclusions:** Subgaleal drains are associated with shorter hospitalisation, greater chance of discharge home, and better functional outcomes than subdural drains.

NEUROVASCULAR AND NEUROINTERVENTIONAL

P.122

Left temporal aneurysm resection: surgical approach in Pial-Pial collateral formation from the posterior temporal artery secondary to left internal artery occlusion

JS Pascual (Calgary) E Guo (Calgary) R Yang (Calgary) KD Langdon (Calgary) S Lama (Calgary) GR Sutherland (Calgary)*

doi: 10.1017/cjn.2024.223

Background: The formation of pial-pial collateral network aneurysms due to carotid occlusion is a rare neurological

phenomenon. This case details a 69-year-old male who developed a pial-pial collateral network aneurysm secondary to left internal carotid artery occlusion, leading to intracranial hemorrhage. **Methods:** The patient presented with altered consciousness due to left temporal intracerebral hemorrhage, subdural hematoma, and intraventricular hemorrhage. Cerebral angiography revealed an occluded left internal carotid artery, with superficial temporal artery (STA) and superior orbital artery anastomosis, and extensive pial-pial collaterals from the posterior temporal artery. A 4 mm aneurysm arising from this collateral network was identified. Surgical intervention involved a left temporal craniectomy and excision of the aneurysm, prioritizing the preservation of the STA. N.B., Informed patient consent was obtained in this study. **Results:** Successful aneurysm removal and preservation of collateral pathways were confirmed by postoperative imaging. The patient exhibited rapid neurological improvement; by postoperative day (POD) one, the patient showed limited response to stimuli. He was extubated by POD4 and discharged on POD27, where he conversed well, was independently ambulatory, and needed minimal to no assistance in activities of daily living. **Conclusions:** This case highlights the need for careful preoperative planning and intraoperative precision, especially in preserving vital collateral vascular pathways.

P.123

Is there an association between geographical location of patients in NS and management of unruptured, incidental intracranial aneurysm?

R Alubankudi (Halifax) J Jarrett (Halifax) A Weeks (Halifax) G Pickett (Halifax)*

doi: 10.1017/cjn.2024.224

Background: Managing unruptured cerebral aneurysms involves monitoring or repair, with complex factors influencing decision-making. Geographical distance from treatment centers is an understudied factor. This study explores a potential relationship in Nova Scotia between proximity to the sole neurosurgical center in Halifax and aneurysm management. **Methods:** A prospectively collected neurosurgery database was used to identify all adults seen for unruptured cerebral aneurysm between Jan 1, 2015 - Dec 31, 2020. Demographic data, aneurysm characteristics, follow-up and treatment information were collected. Univariate and multivariate analyses assessed management differences based on geography, controlling for relevant factors including aneurysm size and location. **Results:** Among 390 patients, 40% were in Halifax, and 60% were outside. No significant difference existed in elective repair (34% vs. 26%, $p=0.143$) and imaging follow-up frequency (2.26 vs. 2.22, $p=0.858$). In-person follow-up was higher within Halifax (1.83 vs. 1.43, $p=0.008$), while virtual follow-up was significant outside Halifax (1.44 vs. 1.01, $p=0.003$). Overall, in-person and elective repair frequencies declined with the COVID-19 peak, whereas virtual follow-up increased. **Conclusions:** No significant association was found between patient location and repair decisions. Patients in closer proximity had more in-person follow-ups, while those farther away had more virtual follow-ups. The COVID-19 pandemic affected follow-up frequencies universally.