

left pons consistent with her symptom. And CT and DVA were located adjacent to CM in the pons. She was treated with antihypertensive medication and her symptoms improved. CT and DVA may present concurrently with CM. And all these concurrent lesions suggest some relationship among them such as spectrum of single disease. Concurrent CT, DVA and CM should be considered when clinicians encounter a patient with eight and a half syndrome.

P051

Aneurysmal Rupture in the Middle Meningeal Artery: Case Report with Unusual Location

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Background: We describe the features of a temporal epidural hematoma associated with the arteriovenous fistula (AVF) and opening adjacent venous lake in the meningeal artery created by a laceration of the dura mater underlying skull fracture. Because of its rarity, our report will be meaningful to neurosurgeons.

Material and Method: A 64-year-old woman underwent craniotomy via pterional approach for clipping of unruptured posterior communicating arterial aneurysm. Removing the bone flap and dural opening resulted in severe diffuse cerebral swelling due to epidural temporal hematoma. Emergent cerebral angiogram revealed ruptured aneurysm in middle meningeal artery. The aneurysm was completely occluded with coils, and hematoma was successfully removed. She could be discharged without neurological deficits.

Result: Because of their potential morbidity and mortality, they must be detected and treated rapidly. The ruptured aneurysm of the meningeal arteries are often detectable only by selective external carotid angiography. This examination must therefore be performed in selected patients, especially in cases of abrupt severe intracranial hematoma after making craniotomy or skull base fracture. Therefore endovascular manage can be a effective treatment option for hematoma associated ruptured aneurysm of the meningeal arteries.

Conclusion: Although rare, ruptured aneurysm of the middle meningeal arteries from extracranial circulations should be considered as a possible cause of epidural hematoma. In conclusion, the ruptured aneurysm of the meningeal arteries must certainly be listed in the differential diagnosis of epidural hematomas.

P052

A Single Centre Audit of IV rt-PA in Patients with Acute Ischaemic Stroke

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Introduction: Intravenous recombinant tissue plasminogen activator (IV rt-PA) administered within 4.5 hours is an evidence-based treatment for stroke. However data of time performances and outcome of IV rt-PA from developing countries, outside the setting of clinical trials, is lacking. Our centre began an acute stroke service in 2009. We present results of an audit of the stroke service.

Methods: The hospital's stroke registry is a prospective record of patients admitted for acute ischaemic stroke. We reviewed our stroke registry and extracted data of patients who were treated with IV rt-PA. We analyzed the demographic data, risk factors for stroke, mean door-to-needle time, rate of symptomatic intracerebral haemorrhage (sICH) and outcome of patients at 3 months (modified Rankin Scale, mRS).

Results: Sixty-one patients received IV rt-PA between July 2009 and Feb 2015. The number of patients receiving IV rt-PA has increased annually to 21 in 2014. Thrombolysed patients were relatively young, (mean age was 57.8 ± 13.0 years) and 73.8% (n = 45) were males. Risk factors identified were hypertension (n = 26, 42.6%), diabetes mellitus (n = 17, 27.8%), atrial fibrillation (n = 7, 11.5%), dyslipidaemia (n = 9, 14.8%) and ischaemic heart disease (n = 11, 18.0%). The mean NIHSS on presentation was 11.8 ± 7.1 . The door-to-needle time improved significantly from an initial 222.5 ± 48.7 minutes to 71.9 ± 32.1 minutes in 2015 (67% reduction). Approximately 41.0% (n = 25) of patients thrombolysed had favourable outcome; mRS 0 to 1 at 3-month follow up. Mortality rate was 11.5% (n = 7) whilst rate of spontaneous intracerebral haemorrhage was 8.2% (n = 5).

Conclusions: The proportion of favourable outcome and rate of sICH and death is similar to those reported in major randomised controlled trials. The door-to-needle time has improved over the years but we are yet to achieve the recommended time of <60 minutes.