**Supplemental Digital Content:**

**Continuation of Methods Section**

We conducted an international multicenter retrospective study of COVID-19 patients with acute ischemic stroke (AIS) and LVO between February 25 and December 30, 2020 across 48 thrombectomy comprehensive stroke centers, predominantly from the North Amereica and Europe. Our control group constituted historical controls of patients presenting with LVO and receiving a MT between January 2018 to December 2020.

Diagnosis of COVID-19 was established using reverse-transcriptase–polymerase-chain-reaction assays of nasopharyngeal samples for identification of SARS-CoV-2.

Charts were reviewed and collected data included A) baseline characteristics including age, gender, and baseline functional status. B) Comorbidities included hypertension, chronic heart disease (coronary artery disease or congestive heart failure), chronic lung disease, chronic kidney disease, chronic liver disease, diabetes mellitus type II, and atrial fibrillation. Cerebrovascular risk factors included hypertension, chronic heart disease, diabetes mellitus type II, and atrial fibrillation. C) Variables specific to COVID-19 included COVID-19 severity, whether stroke was the initial manifestation of COVID-19, duration between COVID-19 symptoms and last known normal (LKN) or stroke onset. COVID-19 severity was defined according to the World Health Organization definition (asymptomatic, mild illness, moderate illness, severe illness, and critical illness.27 D) Stroke characteristics included the Alberta Stroke Program Early CT Score (ASPECTS), National Institutes of Health Stroke Scale score (NIHSS), number of large vessel(s) involved, and location of occlusion. E) Treatment characteristics included tissue plasminogen activator administration (tPA) administration, time metrics including LKN to hospital door and door to arterial access in hours (hrs), type of anesthesia whether general anesthesia or sedation, technique of the mechanical thrombectomy (MT), number of thrombectomy attempt(s), intracranial or extracranial stenting in the acute setting, procedure duration defined as sheath in to sheath out in minutes (mins), and mTICI score. F) Outcomes included complications divided into symptomatic and asymptomatic, sICH, NIHSS score at 24 hours post-MT, length of hospital stay, mRS at discharge, mortality, cause of mortality, disposition, and three months follow-up.

**Study End Points**

Primary outcomes were 1) optimal and complete revascularization defined as modified Thrombolysis In Cerebral Infarction (mTICI) 2b – 3 and 3, respectively. 2) Functional outcome at discharge and at 90 days modified Rankin Scale (mRS); a score of 0-2 was considered favorable and a score of 3-6 was considered unfavorable. 3) Mortality assessed up to 90 days post-discharge due to the ischemic stroke or the underlying COVID-19.

Secondary outcomes were 1) symptomatic intracerebral hemorrhage (sICH) defined as an increase of the National Institute of Health Stroke Scale (NIHSS) by four points in association with any related hemorrhage at the judgment of the treating clinician, 2) predictors of TICI 3 revascularization, and 3) predictors of unfavorable outcome.

**Statistical Analysis**

Data are presented as mean, standard deviation, and 95% confidence interval (CI) for continuous variables, and as frequency for categorical variables. Analysis was carried out using unpaired t-test, Chi-square, and Fisher’s exact tests as appropriate. Patients with and without Covid were compared. Univariate analysis was used to test covariates predictive of the following dependent outcomes: procedural complications (sICH), revascularization (mTICI3), and unfavorable outcome (mRS 3-6). Interaction and confounding was assessed through stratification and relevant expansion covariates. Determinants predictive in univariate analysis (p<0.15)28 were entered into a backwards multivariable logistic regression analysis and the effect of COVID was assessed as clinically relevant in all models. P-values of ≤ 0.05 were considered statistically significant. Statistical analysis was carried out with Stata 10.0 (College Station, TX).

To control for baseline differences, the Covid and non-Covid cohorts were matched, without replacement in a 1:1 ratio, with a caliper of 0.2 standard deviation of the logit of the pro-pensity score using greedy matching. Propensity scores were derived using a logistic regression model accounting for differences in baseline characteristics including age, gender, and cardiovascular risk factors (HTN, DM, atrial fibrillation, heart disease). The PSMATCH2 package developed for Stata (College Station, TX) was used for propensity score derivation and the matching process. Standardized differences were used to assess the balance of baseline data, and differences < 0.20 between pretreatment characteristics of the matched cohorts were considered an adequate balance. The primary and secondary outcomes between cohorts, before and after matching, were compared using binary matched conditional logistic regression analyses, and each of these comparisons were reported as odds ratios (ORs) with 95% confidence intervals (CIs). Fisher's exact test was performed for outcomes with zero frequencies. Missing data were not imputed. Statistical significance was defined as p < 0.05, and all tests were two-tailed.