inflammation. He responded well to high dose dexamethasone therapy and ondansetron and liaison with oncology confirmed radiation induced cerebellitis.

We present an approach to the acute cerebellar syndrome; in particular using this vignette to highlight important signs, investigations, and management issues.

190 PUTTING ORDER INTO INCOORDINATION

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A 68 year-old man presented with rapidly progressive deterioration in mobility, falls, change in speech and diplopia over several days. He had a background of small cell lung cancer diagnosed 8 months previously, treated with chemotherapy and recent adjuvant radiotherapy. Examination revealed severely ataxic gait, multidirectional nystagmus, broken saccades, dysarthria, limb incoordination with past-pointing and dysdiadochokinesis, normal power, reflexes, and sensation. Fundoscopy was unremarkable. He was vomiting profusely.

CT and MRI brain were unremarkable with no evidence of metastases or meningeal enhancement. CT-body showed no signs of metastases and maintained partial response in the left upper lobe and mediastinal nodes. Extensive serum metabolic, infective and onconeuronal antibody screens were normal. Lumbar puncture revealed normal opening pressure with no evidence of infection, cytological dysfunction or occult