vasculitis. Investigations for autoimmune or infective causes were normal. Chest X-ray, echocardiogram, lumbar puncture and a temporal artery biopsy were diagnostically non-contributory. Body CT showed multiple lytic and sclerotic bone lesions, with abnormal lymphadenopathy in the left axilla. Fine needle aspiration of a node showed adenocarcinoma consistent with metastatic oestrogen receptor positive breast cancer. The final diagnosis was non-metastatic paraneoplastic optic neuropathy.

194 THE WIDENING SPECTRUM OF PARANEOPLASTIC DISORDERS: TWO CASES

Adrian Pace,[1] Sonali Dharia,[2] Nicholas Gutowski[2]. [1]*Department of Neurology, Plymouth Hospitals NHS Trust;* [2]*Department of Neurology, Royal Devon and Exeter NHS Foundation Trust*

10.1136/jnnp-2014-309236.194

Paraneoplastic neurological syndromes are non-metastatic disorders triggered by an altered immune response to a neoplasm. Uncommon presentations are increasingly reported, widening the recognised spectrum of these disorders. We present two patients with atypical neurological manifestations that heralded malignancy.

Case 1 A 79 year old woman presented with progressive asymmetrical (R>L) leg weakness. Examination confirmed significant paraparesis (MRC 2/5 bilaterally) with normal muscle bulk and tone, normal sensation and sphincter control, hyporeflexia and downgoing plantars. MRI of the lumbosacral spine was normal. Nerve conduction studies showed an axonal and demyelinating motor neuropathy. CSF was acellular with high protein (2.5 gr/dl) and normal glucose. Body CT revealed a large retrosternal mass consistent with thymoma. Her paraneoplastic motor neuropathy was treated with intravenous immunoglobulin, which clinically stabilised her progression, and referred for surgical removal.

Case 2 A 72 year old woman presented with painless, progressive left-sided visual loss. Fundoscopy excluded arterial occlusion or