immunoglobulin, oral and intravenous corticosteroids, azathioprine, and mycophenolate. Residual hip, abdominal and truncal weakness remained, affecting her gait and posture. CK levels during this period remained normal. MRI demonstrated extensive paravertebral muscle loss with fatty replacement without oedema. Small myopathic units without active features were present on EMG.

**Conclusion** This case illustrates several important aspects of NAM, which remains a rare disorder. Recovery can be incomplete in up to 40%, especially if control is delayed. In our opinion, normalisation of CK is an important target and may be necessary for full recovery, and rising CK may predict relapse. We suggest MRI and EMG of weak muscles may assist in distinguishing persistent myositis from ‘burnt-out’ disease, clarifying whether immunotherapy should be increased or not. However relapse on weaning immunosuppression remains frequent. While SRP antibodies in patients who had also taken statins has been previously reported, the quick sequential onset in this case suggests possible causality.

**REFERENCES**


**073 ACUTE SPINAL INFARCTION: TREATMENT AND OUTCOMES WITH AND WITHOUT HYPERBARIC OXYGEN THERAPY AT FIONA STANLEY HOSPITAL**

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**Introduction** Spinal cord infarction is a potentially devastating disorder commonly presenting with anterior spinal artery syndrome developing over minutes to hours, accounting for an estimated 1% of stroke presentations. Aetologies range from aortic surgical complications, systemic hypotension and other rare causes including fibrocartilaginous embolism and vascular malformations. Diagnosis is clinical combined with restriction of diffusion-weighted MRI. There are no specific treatment guidelines. The evidence for hyperbaric oxygen therapy (HBOT) in acute spinal infarction is mixed. This case series describes ten cases of acute spinal infarction at Fiona Stanley Hospital (FSH), half of which received HBOT.

**Methods** Data for all MRI-proven spinal cord infarctions at FSH between 2014 and 2018 were reviewed.

**Results** Ten patients, median age 55 years (31–74), 60% male. Aetologies: three fibrocartilaginous emboli, five likely atheroembolic disease, one antiphospholipid syndrome, one cryptoegenic. Sixty percent presented with flaccid paraplegia ranging from levels C4 to T11. Five patients received HBOT within a median time of 31 hours from symptom onset, with average 15 treatments. Three patients received triple therapy of HBOT, pentoxifylline and high-volume lumbar-puncture drainages and had median MRC muscle power of 5+ on discharge, compared with 2+ power in those who did not. Nine required inpatient rehabilitation, of average eight weeks’ duration, with median disability at discharge of 3 on the Modified Rankin Scale.

**Conclusion** Spinal infarctions can be severely disabling. Fibrocartilaginous embolism may be more common than previously thought. More research is needed on the role of acute triple therapy with pentoxifylline, spinal drains and HBOT given the marked difference in this case series.

**074 EARLY AUSTRALIAN EXPERIENCE WITH ERENUMAB FOR CHRONIC MIGRAINE**

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**Introduction** Erenumab is available in Australia since October 2018. We review the effectiveness and safety in 2 Australian headache centres.

**Methods** Erenumab (70 mg or 140 mg) was prescribed. We monitored headache days, migraine days, analgesic use, adverse reactions, Headache Impact Test-6 (HIT6) score and Migraine Disability Assessment (MiDAS) score, at baseline and at 3 months. Primary outcomes were reduction in headache and migraine days, and adverse effects. Secondary outcomes were improvement in functional scores and analgesic use.

**Results** 65 patients (ages 18–73; mean 44 years) commencing Erenumab were assessed before and after 3 monthly treatments. The duration of chronic migraine (CM) ranged from 1 to 40 years, with 3 to 16 previous failed prophylactic treatments. There was a >50% response in overall headache days and migraine days in 29% (19/65) and 46% (27/59), respectively. There was a modest (10–49%) response in overall headache days and migraine days in 29% (19/65) and 27% (18/59), respectively. There was no improvement in headache days and migraines in 42% (27/65) and 27% (14/59), respectively. At onset, the mean HIT-6 and MiDAS scores were 66 and 44 months. Primary outcomes were reduction in headache and migraine days, and adverse effects. Secondary outcomes were improvement in functional scores and analgesic use.

**Conclusion** This Australian cohort in tertiary referral refractory migraine patients achieved a significant rate of reduced headache and migraine days with good safety and tolerability.
disorders of connective tissues. Nasal CSF leakage is extremely rare.1

Methods and results We present the case of a 40-year-old woman presented to hospital for few days history of postural headache associated with clear intermittent discharge from right nostril without any signs of meningism. There was no history of trauma. She has a background history of Marfan syndrome with associated complications of ASD repair at age 2, mechanical Aortic and Mitral valve replacement, aortic root repair, previous ST elevation MI with LV dysfunction, automated implantable cardioverter-defibrillator in situ, atrial fibrillation, and Hashimoto’s thyroiditis. Her regular medications are warfarin, bisoprolol and thyroxine. The clear nasal discharge was positive for β-2 transferrin confirming cerebrospinal fluid. Her CT Brain did not reveal any clear site of CSF leak. She had a flexible nasendoscopy which showed normal nasal passageway, no defect in nasal mucosa and no active nasal fluid. Her CT Brain did not reveal any clear site of CSF leakage. She was managed conservatively with strict bed rest and advised to minimise strenuous activity and heavy lifting.

Conclusion Spontaneous cerebrospinal fluid leak is uncommon condition and frequently associated with hereditary disorders of connective tissues. Nasal CSF leakage is extremely rare.1 Testing β-2 transferrin has high sensitivity and specificity.2 Initial treatment may include bed rest, oral or intravenous hydration, oral caffeine or corticosteroids.3 4 If conservative therapy fails, surgical repair with nasal endoscopic approach is recommended.2 5

REFERENCES


A RARE CASE OF ANTI-GLUTAMATE DECARBOXYLASE ANTIBODY SYNDROME PRESENTING WITH RECURRENT VOMITING

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10.1136/jnnp-2019-anzan.64

Introduction Anti-glutamate decarboxylase antibody (anti-GAD) has been linked with various neurological syndromes including stiff-person syndrome, limbic encephalopathy, cerebellar ataxia, eye movement disorders and epilepsy (collectively known as ‘anti-GAD positive neurological syndromes’).1 We describe a very atypical phenotypic presentation of anti-GAD syndrome with unexplained vomiting and weight loss.

Case A 46 years old lady with no past medical or family history of note, presented with 6 months history of severe headaches and recurrent attacks of episodic vomiting (4–6 episodes of multiple vomiting daily) with no identified precipitant and complete normality in between the episodes with no other associated symptoms. She reported 15 kg of unintentional weight loss. Neurological examination and investigations including MRI brain, CT angiogram and liver enzymes, immunoglobulins, thyroid function, vasculitic screen were normal. Upper GI endoscopy, gastric emptying studies, CT imaging of chest, abdomen and pelvis and whole body PET scan were unremarkable. Serum autoimmune antibody screen was positive with high titre of anti-GAD antibody (1200 kU/liter). The cerebrospinal fluid anti-GAD antibody titre was raised at 103.7 kU/liter with otherwise normal parameters including negative oligoclonal bands. The nerve conduction studies did not show continuous motor activity or spasmodic reflex myoclonus (seen in stiff-person syndrome).2 A therapeutic trial of immunosuppression was introduced with moderate improvement in symptoms.

Conclusion Anti-GAD neurological syndromes are rare and this is a unique presentation of the same. It is not completely understood why the presence of one antibody causes varied syndromes. The hypothesis is that the recurrent vomiting is possibly due to diaphragmatic spasm.