Methods Prospective case series.

Results 51 patients admitted for stroke workup were recruited across 2 major tertiary centre's in Sydney to compare WT monitoring for 2 days versus S-patch monitoring for 4 days in the detection of AF. The efficacy to detect AF using both technologies across 76 hours of telemetry was assessed via data extractions and Cardiologist review. A matrix was used to measure nursing/patient satisfaction and setup/resource times were assessed.

84–94% of patients and 75–95% of nursing preferred the S-Patch. Non-parametric tests indicate significant time saving for removal of S-Patch versus WT [2.2 mins vs 5.1 mins ($p=0.00$)]. Efficacy of S-Patch to detect AF following Cardiologist review was greater than WT, with 7 patients identified with AF by S-Patch versus 1 using WT. The S-patch had a false positive rate of 78%.

Conclusion The S-patch had a higher detection rate of AF compared to WT. This allows patients to be anticoagulated appropriately for the prevention of further stroke. Analysis shows patients and staff overwhelmingly prefer the S-Patch. The S-Patch is sensitive in the detection of AF however it showed a high false positive rate. We are confident that further refinement and advances will provide a novel device in the detection of AF.

084 SEPARATING STROKE FROM VESTIBULAR NEURITIS BY VESTIBULAR FUNCTION TEST PARAMETERS

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Introduction Vestibular neuritis (VN) and posterior circulation stroke (PCS) are the commonest causes of acute vestibular syndrome (AVS). We aim to identify discriminators of VN from PCS by testing all five vestibular end-organs in patients presenting with AVS.

Methods Three-dimensional video-head impulse test (v-HIT), cervical and ocular-vestibular evoked myogenic potentials (c- and oVEMP) and subjective visual horizontal (SVH) tests were performed in 22 patients with VN and 22 with PCS. Ipsilesional horizontal, anterior and posterior canal (HC, AC, PC) v-HIT gain and first catch-up saccade characteristics, VEMP amplitude asymmetry-ratios were compared.

Results All VN and 6 PCS patients had positive clinical HIT. Mean time to testing was 4.7 days for VN, 7.0 days for PCS. VN mean ipsilesional HC and AC first saccade amplitude was larger, peak-velocities faster and onset latencies earlier compared to PCS ($p<0.05$). No significant difference between VN and PCS in first saccade characteristics was found in PC. Ipsilesional first saccade amplitude, peak-velocity and duration were significantly different between PCS and controls for all canals ($p<0.05$). A gain <0.68 and first saccade amplitudes $>2.2^\circ$ separated VN from PCS with sensitivities of 95.5% and 86.4% and specificities of 72.7% and 63.6%. First saccade amplitude of $>0.91^\circ$ identified PCS from controls with sensitivity of 68.2% and specificity of 70%. Abnormality rates for AC cVEMP, BC oVEMP and SVH were 42.9%, 50% and 91% for VN and 38.1%, 9% 72% for PCS.

Conclusion v-HIT gain and catch-up saccade metrics are useful separators of VN from PCS. Detailed saccade analysis complements existing vestibular tests.

085 SYNDROME OF TRANSIENT HEADACHE AND NEUROLOGIC DEFICITS WITH CEREBRAL FLUID LYMPHOCYTOSIS (HANDL) AS A MIMIC FOR TRANSIENT ISCHAEMIC ATTACK (TIA)

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Introduction HaNDL is a rare neurological disorder of unknown aetiology that is characterised by headache, neurological deficit and pleocytosis in the cerebrospinal fluid (CSF). It is a benign condition that has spontaneous resolution of symptoms within months.

A 50 year old female presented to Emergency with an acute focal neurological deficit of right sided weakness, dysphasia and dysarthria lasting less than one hour. Over the preceding months she had a new onset of headache. She was worked up for a likely diagnosis of TIA.

Methods Case report.

Results Initial CT Brain(angiography) showed no stroke or other identifiable cause of symptoms.

MRI brain showed excessive nonspecific T2 hyperintensities, requiring further investigation for possible vasculitis. MR angiography was normal and there was no evidence of stroke.

Viral PCR's were negative.

Lumbar puncture (LP) showed pleocytosis (leucocytes $309 \times 10^6/L$), raised intracranial pressure and high protein, raising suspicion for HaNDL. This normalised on subsequent outpatient LP, along with symptoms.

Conclusions

A diagnosis of HaNDL is made as a diagnosis of exclusion, though should be considered as a differential diagnosis for various presentations in which transient acute focal neurology is a presenting complaint.

Due to relatively few reported cases of HaNDL, it is possible that HaNDL is being underdiagnosed due to variability in patient presentation and lack of understanding of the syndrome.

As in this case, when a patient presents with transient acute focal neurology in the absence of headache as a prominent presenting symptom, it is reasonable to consider HaNDL as a differential diagnosis.

086 CLINICAL, INVESTIGATIONAL AND TREATMENT FACTORS DO NOT DETERMINE PROGNOSIS OF PATIENTS WITH INFLAMMATORY NEUROPATHIES

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Introduction Identifying patients who need long-term immunoglobulin (IVIg) treatment in patient with inflammatory

neuropathies is essential as recent treatment trials show a remission rate of up to 40%.

Aims Compare retrospective data on clinical, investigational and treatment factors in patients who have ceased IVIg with patients who have failed a cessation trial.

Methods 15 patients who successfully suspended IVIg infusions were compared with 15 in whom decreasing or stopping IVIg was unsuccessful.

Results 30 patients (12 with CIDP and 3 with MMN in both groups) were diagnosed 39.5 months from onset of symptoms in the successful group vs. 40.7 months in the unsuccessful group ($p=0.953$). There was a significant difference in the summed upper limb sensory amplitudes on electrophysiology prior to starting IVIg between the patients with CIDP (17.4 mV vs. 9.8mV $p=0.007$). There was no difference in the average doses between the groups. A successful cessation trial was attempted at a mean of 60.5 months post starting treatment, compared with 60 months in the unsuccessful patients.

Conclusion There is a need for objective biomarker to measure disease activity because other than one neurophysiology marker, other factors did not help predict a successful cessation trial of IVIg.

087 ENDOVASCULAR CLOT RETRIEVAL (ECR) IN THE ELDERLY. FOR BETTER OR WORSE IN THE REAL WORLD?

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Introduction

Across multicentre trials ECR is safe and effective in octogenarians. Despite RCT evidence elderly patients may be denied ECR due to perceived poor risk-benefit. We examine impact of age on ECR outcomes and outcomes in transcatheter aortic valve implantation (TAVI) cases (where stroke risk is high), in a real world setting.

Methods We analysed 311 consecutive ECR cases between 2016 and 2019 in 10 year age bands for ECR outcomes including 90 day mRS and mortality. Impact of premorbid function (mRS), NIHSS, recorded co-morbidities, and aetiology was assessed. TAVI case outcomes were examined.

Results Thirty one percent of ECR outcome cases were over 79 years of age; 90 day mortality was 34%; 25% had a 90 day mRS 0–2. Early NIHSS improvement was 5. Ninety-day mortality and mRS 0–2 for 10–19 ($n=3$), 20–29 ($n=2$), 30–39 ($n=4$), 40–49 ($n=23$), 50–59 ($n=27$), 60–69 ($n=69$), 70–79 ($n=84$), 80–89 ($n=62$) and 90–99 ($n=11$) years were 0 and 100%, 0 and 100%, 33 and 67%, 4 and 78%, 15 and 52%, 13 and 49%, 17 and 33%, 24 and 2% and 55 and 18%, respectively. There was 9% lost to follow-up.

Six TAVI cases had a NIHSS of 8–20 and pre-morbid mRS<3, four with mRS 0. Mean 24 hour NIHSS improvement was 8.

Conclusion Without age exclusions older patients had worse unadjusted outcomes. However, patients over 79 years had clinically important early improvement in NIHSS score and

ninety day outcomes were comparable to favourable RCT data and TAVI patients also had early improvement.

088 CLADRIBINE TABLETS WERE ASSOCIATED WITH RAPID ONSET OF IMPROVEMENTS IN MRI OUTCOMES IN THE ORACLE-MS TRIAL

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Introduction In ORACLE-MS (616 subjects with a first demyelinating event at high risk of converting to multiple sclerosis), cladribine tablets (CT) 10 mg (3.5 mg/kg or 5.25 mg/kg cumulative dose over 2 years) significantly delayed the time-to-conversion to clinically definite multiple sclerosis (CDMS), and reduced new/persisting T1 gadolinium-enhancing (T1 Gd+), new/enlarged or active T2 and combined unique active (CUA) lesion number. Here, the timing of CT effect is evaluated.

Methods MRI scans were performed at screening and every 12 weeks, for non-converting CDMS subjects. MRI-based endpoints were analyzed using analysis of covariance (ANCOVA) and negative binomial models. The temporal effects of the first yearly treatment course of CT and placebo on T1 Gd+, active T2, and CUA lesions were evaluated.

Results 96 weeks: the reduction in mean T1 Gd+, active T2, or CUA lesion number per patient per scan was nominally significantly greater for CT versus placebo ($p<0.0001$). Early change in Gd+ lesion volume (at Week 13) from baseline was CT, -155.73 mm³; placebo, -14.76 mm³. Comparatively larger reductions in mean active T2 and CUA lesion numbers with CT at Week 13 versus placebo were observed (active T2: CT, -1.25; placebo, -1.43; CUA: CT, -1.56; placebo, -2.41). The mean number of T1 Gd+ lesions at 13 weeks following CT was 0.37 versus 1.0 with placebo.

Conclusions MRI data from ORACLE-MS subjects suggest the first yearly treatment course of CT has a rapid onset of action, with beneficial treatment effects on active lesion number and volume evident by Week 13.

089 BREAKING THE CYCLE OF CHRONIC DAILY HEADACHE WITH A LOW-DOSE SUBCUTANEOUS LIGNOCAINE AND KETAMINE INFUSION

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Introduction Management of chronic migraine includes correcting analgesic rebound headache and implementing suitable medication for prevention and acute episodes. However, in many cases this management paradigm oversimplifies the complexity of chronic migraine, particularly the entrenched central pathways that perpetuate chronic migraine. Intravenous