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 IVlg with patients who have failed a cessation trial.

Methods 15 patients who successfully suspended IVlg infusions were compared with 15 in whom decreasing or stopping IVlg 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 IVlg between the patients with CIDP (17.4 mV vs. 9.8 mV 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 IVlg.

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**Abstracts**

**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 = 33), 20–29 (n = 2), 30–39 (n = 2), 40–49 (n = 2), 50–59 (n = 2), 60–69 (n = 2), 70–79 (n = 2), 80–89 (n = 6), 90–99 (n = 7) 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 MRR 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
lignocaine can curtail chronic migraine and analgesic rebound headache (1). Further, ketamine provides short-term analgesia and enables reduction in central sensitisation of pain pathways, particularly in the setting of codeine/opioid overdose (2). This paper describes use of subcutaneous lignocaine and ketamine infusion in chronic migraine.

Methods A prospective observational cohort study was undertaken in patients with chronic migraine. Patients received a prolonged subcutaneous lignocaine and ketamine infusion (mean duration 11 days) and underwent evaluation at four-time points over six months. The effects on the excitability of motor axons in the median nerve were documented using standard procedures.

Results Fourteen patients were recruited. The infusion was well tolerated; no major side effects were seen. There were no significant long-term changes in the excitability of motor axons. At six months, 13/14 patients had sustained benefit. Three of 4 patients remained free of analgesic rebound headache. One patient remained headache-free. Conversion to episodic migraine occurred in 6/14. Improvement in chronic migraine was reported by 6/14. Three of six were able to return to work, with 1 returning to studies. Benefit was greater in those with depression and history of opioid/codeine use.

Conclusion Subcutaneous lignocaine and ketamine can help break entrenched in chronic migraine as part of a structured management plan.