Conclusion Thrombolysis rates in New Zealand continue to rise and now surpass the more recent 10% Ministry of Health target. The continued reduction in door-to-needle time is also an indication of continued service improvement resulting in better patient outcome. However, there are still to be opportunities for improvement.

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CASE REPORT: TO STENT, OR NOT TO STENT? THE PALE CAST OF EVIDENCE-BASED PRACTICE IN ACUTE STROKE

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Introduction With approximately 200 procedures performed in the last year at our centre, worthwhile clinical lessons continue to emerge in the practice of endovascular clot retrieval (ECR) for acute stroke. This case demonstrates the value of considered clinical appraisal in a dynamic, information-rich setting. A 68 year-old man with established vertebrobasilar atherosclerotic disease developed capricious, blood pressure-sensitive neurological deficits after successful ECR for a basilar artery stroke, inviting the possibility of further intervention in the form of intracranial stenting. We avoided pursuing this course of action in favour of a more measured approach, entailing the provision of vasopressor support over the following week.

Method Following ECR, our patient was admitted to the intensive care unit for continuous blood pressure monitoring and close observation of his neurological deficits with serial NIHSS (National Institutes of Health Stroke Scale) scoring. Systolic blood pressures were maintained between 140–160 mmHg using vasopressor support, with the aim of allowing time for recovery of vascular autoregulation and collateralization.

Results Over six days, the patient developed moderate left upper and lower limb weakness. An MRI performed on Day 5 revealed limited interval infarction of the right hemipons and cerebellum, with complete re-occlusion of the mid-basilar arterial segment. He left the ICU with a NIHSS score of 7, and was living independently at 90-day follow-up (Modified Rankin Score 1).

Conclusion The ultimately favourable net outcome for our patient clearly illustrates the imperative to remain within the boundaries of evidence-based practice in this bold and rapidly evolving discipline.

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LATE-ONSET PARADOXICAL REACTIONS IN NEUROTUBERCULOSIS PRESENTING 18 MONTHS AND 20 YEARS AFTER TREATMENT

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Introduction Paradoxical reactions (PRs) during treatment of neurotuberculosis are common but late-onset PRs after

completion of anti-tuberculous treatment are reported very rarely. The management of late-onset PRs is challenging as excluding other diagnoses is difficult without invasive testing.

Methods Two cases of late-onset PRs after treatment for neurotuberculosis are reported. The timing of onset, clinical and radiological features of these PRs are described and the diagnostic work up and outcomes after empiric immunosuppression reviewed.

Results A 24-year-old woman presented with right-sided focal motor seizures 18 months after receiving anti-tuberculous treatment for neurotuberculosis. MRI showed enlargement of a previous left frontal tuberculoma with extensive oedema. A biopsy was not performed as the lesion involved eloquent brain and the patient declined a lumbar puncture. She was treated empirically with corticosteroids for six months and had clinical and radiological improvement.

A 56-year-old woman presented with left leg weakness and numbness 20 years after treatment for multiple cerebral tuberculomas. MRI showed a new confluent area of T2 hyperintensity in the right frontal and parietal lobes. Cerebrospinal fluid was negative for acid-fast bacilli. She was treated with corticosteroids for 2 months with progressive improvement.

Conclusions Late onset PRs to neurotuberculosis can occur months to years after completing anti-tuberculous therapy. Recognising this entity is important so unnecessary treatments and brain biopsy may be avoided. Empiric immunosuppression with corticosteroids appears to be safe if early follow up and repeat imaging is arranged.

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NEW ZEALAND HOSPITAL STROKE SERVICE PROVISION: A NATIONAL SURVEY

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Introduction The REGIONS Care study assesses stroke care throughout New Zealand. It includes a national audit and here we present organisational survey results assessing current availability of interventions and management approaches in each hospital.

Methods All 20 District Health Boards were invited to complete a survey about patients managed per annum, care setting, and service provision. Results were grouped into rural and urban groups to assess for geographic differences.

Results All NZ hospitals managing stroke patients completed the survey. Results found that of these hospitals 92% have an acute stroke unit, 85% have a TIA pathway, but only 58% offer rapid access specialist TIA services. 100% offer thrombolysis, 92% use pre-hospital notification and rapid ED triage system, and 73% an in-hospital 'code stroke' alert. 50% have access to thrombectomy. Only 32% offer a dedicated inpatient stroke rehabilitation unit. While 92% provide community rehabilitation, only 11% offer early supported discharge programmes. 87% routinely provide stroke patient education, but only 54% provide individualised stroke care plans at