

(MOG) antibody positive but negative for (Aquaporin -4) AQP-4 antibodies. Radiological findings on MRI of the brain and spine was suggestive of multiple sclerosis (MS). Whilst receiving intravenous immunoglobulin (IVIG) as a bridging therapy to Multiple Sclerosis (MS) modifying therapy, the patient developed severe adverse reaction to IVIG with desquamation of her hands and legs. Furthermore, she did not achieve satisfactory disease control with Ocrelizumab. Has cushingoid features secondary to long term high dose steroid therapy.

Conclusions To highlight the challenges and difficulty in managing a patient with refractory MOG antibody optic neuritis and its impact on the quality of life of the patient. To demonstrate the gap in available clinical evidence in the management of recurrent MOG antibody positive optic neuritis. To initiate an open discussion regarding the treatment of these challenging group of patients

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INTRAVENTRICULAR MIGRATION OF INTRAOCULAR SILICONE OIL

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10.1136/bmjno-2021-ANZAN.96

Introduction We report a case of intraventricular migration of intraocular silicone oil.

Case A 53-year-old male presented with a decreased level of consciousness. His past medical history included bilateral retinal detachment, atrial fibrillation and ischaemic stroke. Initial blood tests and chest X-ray were consistent with a community acquire pneumonia. He was started on a 5-day course of IV ceftriaxone and azithromycin with improvement in his symptoms.

A CT brain was performed upon presentation given his conscious state. This demonstrated a high density in the right globe with tracking along the optic nerve and bilateral homogenous isointense spherical masses in the frontal horns of the lateral ventricles. Imaging was initially reported as bilateral vitreous haemorrhages, an optic chiasm lesion and intraventricular haemorrhage. Follow-up MRI brain confirmed the biventricular masses with evidence of a chemical shift artefact on T1 and T2 sequences. There was disappearance on the masses on fat-suppressed T1-sequences. Images were reviewed in the combined neurology-neuroradiology meeting with the diagnosis made of cerebral migration of silicone oil.

Conclusion Intraventricular migration is a rarely reported complication following intraocular silicone endotamponade. The precise mechanism of migration is unknown. As silicone appears hyperintense on CT, it can mimic a haemorrhage or mass. Cases of misidentification of intraventricular silicone have resulted in protracted hospital admissions and surgical biopsy. Typical MRI findings and a comprehensive clinical

history allow for accurate identification. Early and accurate recognition is critical to avoiding unnecessary investigation and patient morbidity.

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CASE REPORT: A ROLE FOR OCRELIZUMAB FOR MULTIPLE SCLEROSIS WITH OCULAR SARCOIDOSIS?

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10.1136/bmjno-2021-ANZAN.97

Introduction Multiple sclerosis causes a variety of clinical neurological features which may overlap with sarcoidosis with central nervous system involvement. Rarely, concurrent diagnosis of MS and sarcoidosis in an individual has been reported. Currently, best management strategy for these individuals with this dual pathology remains unknown.

Case A 54-year-old man with a 14-year history of isolated ocular sarcoidosis, as well as type 2 diabetes mellitus, hypertension, and dyslipidemia, presented with ongoing right-hand paresthesia. Gadolinium-enhanced neuroaxis MRI imaging revealed comparatively stable non-enhancing appearances of previously known numerous punctate supratentorial subcortical white matter hyperintensities, and a new non-enhancing right ventrolateral C3/4 cervical spinal cord hyperintense lesion. The radiological pattern in combination with positive oligoclonal bands and elevated protein levels on cerebrospinal fluid testing, with normal serum ACE level, was thought to favour a diagnosis of multiple sclerosis (with McDonald criteria fulfillment), rather than neurosarcoidosis. In addition to his sarcoidosis treatment comprising prednisolone and hydroxychloroquine (later changed to mycophenolate), Ocrelizumab was selected as initial disease modifying therapy for his new relapsing remitting multiple sclerosis, due to postulated benefits for his sarcoidosis as well based on ocrelizumab's similarity to rituximab, an established treatment option in refractory sarcoidosis.

Conclusion This case highlights several key issues:

- Recognising the possibility of co-occurrence of CNS demyelinating disease in sarcoidosis
- The diagnostic challenge of ascertaining new neurological changes in sarcoidosis
- The challenge of managing concurrent inflammatory conditions of distinctly separate aetiology

We propose that Ocrelizumab has potential utility as an option in streamlining therapeutic management of this dual pathology.

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STROKE-LIKE MIGRAINE ATTACKS AFTER RADIATION THERAPY: BE SMART AND ORDER AN EEG

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10.1136/bmjno-2021-ANZAN.98

Background Seizures may be a feature of SMART (stroke-like migraine attacks after radiation therapy) syndrome but their role in the pathophysiology and clinical presentation is unclear.