did not return to pre-morbid levels. The MRI lesions resolved and did not recur.

Conclusion Focal vasculitis is rare but may result in neuronal loss and specific cortical damage and atrophy, in this case leading to embouchure dystonia.

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102 LAMBERT EATON MYAESTHENIC SYNDROME IN THE ABSENCE OF MALIGNANCY

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Introduction We report a case of Lambert Eaton Myaesthenic Syndrome (LEMS) in an 85-year-old gentleman with no active malignancy.

Case An 85-year-old gentleman presented with a 3-month history of proximal weakness, confusion, nausea and vomiting. His medical history included gastric adenocarcinoma with curative resection 21-years ago and a 2-year history of a stable sensorimotor peripheral neuropathy. During his admission he experienced an episode of new onset fluctuating diplopia. Neurological examination demonstrated mild upper and lower limb non-fatiguable weakness. There was no detectable cranial nerve palsy.

A myasthenia antibody panel was ordered. Voltage-gated-calcium-channel-antibodies were positive (47pM) (normal range < 30pM). Repetitive nerve stimulation demonstrated an increment in compound muscle action potential of the right nasalis and right abductor digiti minimi following exercise and high-rate stimulation consistent with the clinical diagnosis of LEMS. Investigation for malignancy including tumour markers, CT chest, abdomen and pelvis, MRI-pancreas and whole body PET scan were unremarkable.

The patient underwent a 1-month period of inpatient rehabilitation and was discharged home. At 6 months, he remains well with no further episodes of diplopia or weakness. To date, no malignancy has been identified.

Conclusion LEMS in absence of an identified malignancy is an uncommon diagnosis. Those cases that have been documented are also more likely to occur in younger patients. The case we present here highlights a constellation of vague seemingly discordant symptoms with a unifying diagnosis and offers the patient a chance to be actively monitored for the development of malignancy in the future.

103 AN UNDIFFERENTIATED AUTOIMMUNE NEUROINFLAMMATORY ILLNESS ASSOCIATED WITH LOW CSF HYPOCRETIN & CENTRAL HYPOTHALAMIC DYSREGULATION

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Introduction This case report explores a possible undifferentiated autoimmune neuroinflammatory illness presenting with recurrent fevers, abdominal pain, hypersomnolence and sleep attacks with low cerebrospinal fluid (CSF) hypocretin, and a partial response to anakinra, a human interleukin 1 receptor antagonist.

Case Presentation A 19 year old female presented with 5 years of abdominal pain and fatigue with no clear aetiology identified following extensive investigation. She subsequently was found to have recurrent fevers to 38°C, an intermittent fine, macular rash and sudden sleeping at inappropriate times. Her brain MRI was normal and (CSF) showed normal protein and no white cells, but a low hypocretin level (<200 units). Further investigations including whole exome sequencing, gastrointestinal, autoimmune and metabolic assessments, yielded limited findings. Previous therapy with colchicine had been ineffective.

Management and Outcome For a presumptive diagnosis of an undifferentiated autoinflammatory disorder, she was received prednisolone 10 mg daily for 4 weeks with no benefit. She then initiated anakinra, which improved in rash and sleep attacks. Despite initially controlling her recurrent fevers for a period of four weeks, this symptom ultimately recurred, with ongoing abdominal pain.

Discussion Low levels of hypocretin in the CSF has been associated with narcolepsy type 1 and has thought to been associated with an undefined autoimmune mechanism. It is hypothesised that her hypothalamic orexin has been altered due to these inflammatory changes leading to body temperature dysregulation and sleep disorder. Interestingly the hypersomnolence appear to have improved with anakinra, a therapy not typically used in narcolepsy.

104 OVERLAPPING AUTOIMMUNITY: A CASE OF CONCOMITANT AQUAPORIN-4 AND MYELIN OLIGODENDROCYTE GLYCOPROTEIN (MOG) ANTIBODY POSITIVITY IN NEUROMYELITIS OPTICA SPECTRUM DISORDER

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Objectives To describe a rare case of double antibody positive Neuromyelitis Optica Spectrum Disorder (NMOSD) with both Aquaporin-4 and MOG antibodies, occurring following a Pertussis infection in a patient with a history of auto-immunity.

Methods Retrospective review of clinical records.

Results A 41-year-old Chinese woman with a history of Systemic Lupus Erythematosus presented with a sub-acute onset of progressive gait ataxia and urinary retention occurring seven days after a confirmed Bordetella pertussis infection. Magnetic resonance imaging revealed extensive subcortical and thalamic T2/FLAIR hyperintensities with subtle enhancement, and a longitudinally extensive non-enhancing spinal cord lesion (T1-T7), without optic nerve involvement. Cerebrospinal fluid protein was raised (0.55 g/L) with 7 mononuclear cells and matched oligoclonal bands. Viral PCRs were negative including JC virus and Pertussis. Established live cell-based immunoassays revealed positivity for both Aquaporin-4 antibodies (in CSF and serum) and MOG antibodies in high