requiring further cerebrospinal fluid diversion procedures (n=10, 8%).

Conclusion Our data supports the use of ONSF in the setting of raised intracranial pressure, papilloedema, and in visual failure not due to IIH or CVST and when other CSF diversion procedures or medical therapies have failed.

Posters

2209 BILATERAL FRONTO-PARIETAL SUBCORTICAL CYTOTOXIC OEDEMA ASSOCIATED WITH HEADACHE AND TRANSIENT NEUROLOGICAL SYMPTOMS FOLLOWING FLOW DIVERSION STENTING OF AN ANTERIOR CEREBRAL ARTERY ANEURYSM

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Endovascular treatment of cerebral aneurysms with flow diverting stents (FDS) divert blood flow away from an aneurysm and into the native vessel. Complications are less than with surgery[1] but may include haemorrhage, ischemia[2–4] and rarely brain oedema.[5] A 48-year-old woman underwent a suitability assessment for kidney donation. Multiple aneurysms involving the splenic, superior mesenteric and gastroduodenal arteries were found. Further screening identified a 1.9mm x 2.7mm berry aneurysm of the left distal pericallosal Anterior Communicating Artery. By PHASES criteria, her risk of rupture in five years was 0.9%; however, her actual risk was likely higher given the suspicion for a vascular fragility syndrome. FDS insertion to the left Azygos ACA was performed.

Within twenty-four hours, she developed ataxia, nausea, headache and confusion. MRI demonstrated bilateral frontoparietal subcortical cytotoxic oedema with perivenular enhancement surrounding the stent. Over four weeks, there was clinical recovery. Repeat imaging at three months showed resolution of enhancement but persistent white matter changes in the left peri-rolandic and parietal lobes. Delayed nonischemic cerebral enhancing lesions are rarely reported after endovascular treatment.[5] These lesions are attributed to foreign-body emboli and inflammatory reactions. While cerebral oedema has been previously recognised shortly after FDS insertion, often associated with headaches,[6] our patient demonstrated a more persistent clinical syndrome and inflammatory changes on imaging. This potential complication is important to recognise as anti-inflammatory medication may be considered.[7] The intensity of reaction observed may relate to her underlying vascular fragility and increased blood-brain barrier disruption.

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2213 IMPACT OF PANDEMIC ON BOTOX TREATMENT AND TREATMENT EFFECT IN PATIENTS WITH CHRONIC MIGRAINE

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Objectives We studied the impact of the pandemic on Botox treatment and treatment effect in patients with chronic migraine at 1.5 years into the pandemic, in headache clinics in different countries.

Methods We carried out a multicentre survey of patients with chronic migraine being managed in headache clinics from July to October 2021 in 5 countries (Australia, Italy, Spain, Colombia and Germany). We collected information including demographics, comorbidities, current medications, acute medications use, monthly headache and migraine days (MHD), MHD 2 years ago in 2019, Depression anxiety stress-21 scale (DASS21) scores, Headache Impact Test 6 (HIT6), pandemic and Botox related questions. The primary outcome measured was change in MHD.

Results We collected data from 49 patients (average age 46 years old, 80% female). At baseline, the current preventive was Botox in 47 out of the 49 patients, monthly acute medication use was 6.6 (0–30), the DASS21 score was 21.8 (0–66) and HIT6 score 59 (40–71). The 2021 MHD was 11.3 (1–30) and the 2019 MHD was 18 (3–30), with the change in MHD -6.7. All patients were affected by the pandemic in many aspects including work, family, social, travel restrictions. 15/45 said their migraines worsened with the pandemic. 39/45 did not have a change in the effect of Botox treatment.

Conclusions Headache and migraine control improved by -6.7 days per month compared to 2 years ago. Headache centres had minimised disruptions to patients receiving Botox for their migraine treatment. The Botox treatment effect remained stable in the pandemic.