PLR and NLR for a negative HIT in stroke was 5.85 (95% CI 3.07 – 10.6) and 0.17 (95% CI 0.08 – 0.30) respectively. PLR and NLR for peripheral HINT pattern for PV was 17.3 (95% CI 8.38 – 32.1) and 0.15 (95% CI 0.07 – 0.26) respectively. PLR and NLR for central HINT pattern for stroke was 5.61 (95% CI 4.19 – 7.7) and 0.06 (95% CI 0.03 – 0.12) respectively.

Conclusion The HIT and HINT exams appear moderately good discriminators of central and peripheral vertigo. However, these results may not apply in the ED setting as most papers evaluated these tests beyond 24 hours.

2386 DYSTONIC STRIDOR AND LARYNGEAL MYOCLONUS IN A MEDULLOBLASTOMA SURVIVOR PRECIPITATED BY REDUCTION IN INTRACRANIAL PRESSURE

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Background Whilst stridor related to bilateral vocal cord paralysis (BVCP) is a recognised complication of increased intracranial pressure, it typically resolves with ventricular-peritoneal (VP) shunting. We present a case where tracheostomy was needed after successful VP shunting.

Case A 33-year-old-man presented with headache, slurred speech and immobility. His background included resected medulloblastoma with head-neck radiotherapy (aged 8), long-term VP shunt, and post-treatment ataxia which had progressed over 2 years with development of intermittent nocturnal stridor. He underwent emergent shunt revision for a distally blocked shunt, with resolution of hydrocephalus. Two days afterwards, he developed hiccups and worsened stridor which progressed to respiratory obstruction over 24 hours. Laryngoscopy showed tightly adducted midline vocal folds with coarse pharyngeal, palatal, and tongue myorhythmia (3 Hz). There was no response to benzodiazepines and no epileptiform activity on EEG. He had loss of gag reflex on neurological examination with normal eye movements. A cerebral and neck MRI showed resolution of hydrocephalus and post-treatment changes related to previous medulloblastoma. There has unfortunately been no improvement in vocal fold movement over 3 weeks.

Discussion Subacute stridor may be due to pathological upper motor neurone activation of the branchial motor component of the vagal nerves with this person's background brain injury.[1] Tight acute midline cord positioning and myoclonus may be unusually caused by bilateral recurrent laryngeal nerve lesions secondary to changes in intracranial pressure,[2 3] but is not the favoured sole mechanism here. Botulinum toxin therapy could provide benefit but may compromise a future safe swallow.

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2388 DIAGNOSTIC CHALLENGES ASSOCIATED WITH GRANULOMATOUS DISEASES: AN ILLUSTRATIVE CASE REPORT

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Case Report A 29-year-old female presented with a 4-month history of right-sided hemifacial sensory disturbance. Examination revealed reduced pain and temperature sensation in the right V1, V2 and V3 regions and a diminished right corneal reflex. Past history included intermittent herpes labialis and travel to India twice in the prior 5 years.

Enhanced brain and skull-base magnetic resonance imaging (MRI) revealed enhancement at the cisternal segment of the right trigeminal nerve and right infraorbital nerve T2-hyperintensity. Diffuse extra-axial enhancement was noted in right Meckel's cave, extending into the posterolateral cavernous sinus. Positron emission tomography (PET) imaging demonstrated markedly increased metabolism in the right Meckel's cave and metabolism in the hilar and mediastinal lymph nodes consistent with sarcoidosis. Lymph node biopsies were inconclusive but revealed a possible granuloma. Right trigeminal nerve biopsy was subsequently performed. Histopathology revealed non-caseating granulomas with few acid-fast bacilli present. Primary neuritic leprosy was diagnosed and a 12-month treatment course of rifampicin, dapsone and clofazimine was commenced.

Repeat MRI 3-months post-treatment demonstrated reduced enhancement in the right cavernous sinus. Clinically her symptoms improved with antibacterial and steroid therapy. Repeat PET imaging revealed resolution of the Meckel's cave changes but increased metabolism in thoracic and abdominal lymph nodes, raising the possibility of an alternative diagnosis (i.e. sarcoidosis) or dual pathology. Pregnancy halted further diagnostic work up.

This case highlights the complexities associated with diagnosing granulomatous disease even with access to multimodal imaging and biopsy sites, and the need to revisit the diagnosis if there are atypical features.

2389 THE YIELD OF EEG AND OTHER NEUROLOGICAL INVESTIGATIONS IN PATIENTS WITH NEW ONSET OF PSYCHIATRIC SYMPTOMS

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Objectives To establish the diagnostic yield of electroencephalogram (EEG) and other investigations for evaluation of limbic encephalitis in patients with new onset psychiatric symptoms.

Methods A retrospective audit was conducted of all EEGs performed between July 2020 to August 2021 for workup of new-onset psychiatric symptoms at a tertiary neurology referral centre. Data was obtained from electronic medical records including patient history, neurological examination findings, results of investigations including EEG, brain magnetic