unable to manage at home. He had frequent falls, shuffling gait, slow movements, right sided limb tremor along with difficulty with eye movements, dysphagia and several collapses. On examination, he had gait and other features of parkinsonism (tremor, bradykinesia, rigidity and postural instability). He also had ophthalmoparesis, suggestive of PSP.

However, there were some incongruencies that prompted for a more detailed examination. This revealed subtle but definite features in keeping with functional parkinsonism. The patient was referred to physiotherapy and cognitive behavioural therapy. He is also awaiting a dopamine transporter imaging.

During my oral presentation, I will be showing videos of this patient's examination findings and present a literature review. This case demonstrates how easy it is to miss the signs if they are not carefully and actively looked for. It also highlights the importance of challenging and digging deeper when things do not quite fit.

2408 THE FOREST NOT THE TREES: A PRESENTATION OF A CHALLENGING CASE

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A 37-years-old NZ European man presented with a history of five years of progressive neurological deficits. These included dysarthria, hyper-salivation, vivid dreams, sleep disordered breathing, elevated hemi-diaphragm, left upper limb paraesthesia, syncopal episodes, lethargy, irregular bowels, difficulty passing urine, difficulty with temperature regulation, locked and painful jaw, anxiety, reduced sleep and headaches. On examination, he had mild dysarthria, wasted tongue with deviation to left and weakness on the left. The reflexes were brisk in the lower limbs with an up-going plantar response on the left. MRI revealed an ill-defined heterogeneous enhancement of the medulla extending to the right cerebellar peduncle. The patient underwent extensive work up and treatment trial with steroids with a working diagnosis of Neuro-sarcoidosis. He developed several further symptoms of tremors and further paraesthesia over the next three months. The patient had a sudden death and the final diagnosis of Alexander disease was revealed in his autopsy.

Retrospectively, the symptoms collectively clearly point to a neurological disorder, but during the five years of the disease progression, his complaints were approached individually as separate issues by multiple specialities. Due to this, despite the numerous red flags, these were unrecognised and the patient presented to Neurology with an advanced illness. This is a valuable case for learning and it reminds us how an eye for detail and careful observation in history and examination is critical, especially for patients presenting as a diagnostic challenge. This very fact is also what makes Neurology such a fascinating and intriguing specialty.

2409 AN ATYPICAL PRESENTATION OF AUTOIMMUNE GLIAL FIBRILLARY ACIDIC PROTEIN (GFAP) ASTROCYTOPATHY WITH EXTENSIVE SPINAL CORD DISEASE WITHOUT BRAIN INVOLVEMENT

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Autoimmune glial fibrillary acidic protein (GFAP) astrocytopathy is a novel central nervous system disorder that presents with one or more of meningitis, encephalitis and myelitis. 95% of patients present with either meningoencephalitis or meningo-encephalo-myelitis. Myelitis without cerebral involvement is rare and thought to represent only about 5% or less of cases.

We report, along with review of literature, a rare presentation of autoimmune GFAP astrocytopathy, who presented with myelitis without encephalitis and experienced initial misdiagnosis and a delay in the diagnosis.

A 25-year-old male, kiwi packer, migrant from India presented with meningism (fevers, headache, neck stiffness, photophobia, nausea and vomiting) with subsequent development of urinary retention and progressive weakness and sensory change in the limbs. CSF examination revealed the GFAP-IgG with significantly elevated lymphocytes and protein. Magnetic resonance imaging revealed a rare finding of longitudinally extensive myelitis extending from the C2 to T11 level without any brain lesions. He had significantly elevated lymphocytes and protein in the CSF with the presence of GFAP-IgG. Interestingly, He was initially diagnosed with viral meningitis and had multiple re-presentations to the hospital with ongoing deterioration in clinical status despite antibiotic and antiviral therapy. This led to further investigations and immunotherapy (IV steroids and plasma exchange) with good recovery.

This is a valuable case for learning, which reports an uncommon presentation of a rare disorder. It highlights the importance of detailed history and examination, having broad differentials in mind and early re-evaluation of diagnosis when things do not go as planned.

2413 DOES SERUM NEUROFILAMENT LIGHT CHAIN LEVEL CONTRIBUTE TO THE PREDICTION OF TREATMENT RESPONSE IN MULTIPLE SCLEROSIS?

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