Parietal lobe lesions, in previously normal adults, can cause cognitive deficits of: agnosias – neglect syndromes of illness; body image of self and others; higher order sensations, graphesthesia; motor imagery, self-reflection episodic memory retrieval, praxis, empathy, emotional content of speech. Degree and timing of recovery of each lost function, if it occurs, varies.

An ill person may freely withhold consent, though the converse does necessarily hold: the giving of consent does not mean a valid choice was made – if awareness was impaired. Capacity, and 'informed' consent, especially in parietal lesions, for fully understanding implications of a possible future outcome – which, in the main, is what matters – is very difficult to establish with current neuropsychological tools. This leaves only the specificity of consent possible. Later recovery from the lesion, may allow for valid consent.

Conclusion Medico-legally, these provocative challenges will only increase in the future with an ageing population and more stroke survivors. The questions are not merely hypothetical: difficulties also arise in the spectrum of minimal cognitive impairment to dementia, where the burden of disease may fall on different cerebral lobes.

2422 PARRY ROMBERG SYNDROME/PROGRESSIVE FACIAL ATROPHY (PRS/PFA)-WHO AND HOW OFTEN TO FOLLOW UP

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Objective Justify multi-disciplinary team policy for Follow-up

PRS/PFA is a rare condition with variable presentation though progressive unilateral wasting of the face is the hallmark. It affects females more than males and the left side more than the right and may present to dermatologists, dentists, plastic surgeons, rheumatologists or neurologists. Cause is unclear and symptoms are treated on their merit. Mood is commonly affected and consensus is developing that it should be managed in a multi-disciplinary team setting, including psychologist.

An 18yr old female presented with mild left face wasting. Neurologic examination revealed a mild scoliosis and no morphea.

Childhood PRS/PFA is managed closely with whole-family involvement. Extra-cranial manifestations (ECM) occur in over 40%. Findings of: progressive intra-cranial atrophy, T2 hyperintensities, dementia, epilepsy, calcification, bleeding, trigeminal neuralgia, headaches, movement disorders; numerous eye complications; dental, Temporo-mandibular joint, joint and skin (morphea and sclerosis) – can arise at any time from diagnosis.

As a rare condition, with limited physician exposure, protocols for review differ for each specialty. With around a hundred ECM possible – spread over different fields of expertise, a unified approach would make for efficient use of time and resources over this long-term disease process. Progression of PRS can be expected mainly in the first 10 years. Recurrences and progression, after years of stability, have been reported.

Conclusion Recommendations have been made for: team review each 3–6 months for the first 10 years; MRI each 12–24 months; eye review each 6 months; 3D photography each 6 months

2423 ADMINISTRATION OF SUBCUTANEOUS IMMUNOGLOBULIN (HIZENTRA®) IN THE HOME SETTING THROUGH THE CSL BEHRING CARES PATIENT SUPPORT PROGRAM FOR PATIENTS WITH CIDP

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Objectives Treatment of CIDP includes both intravenous immunoglobulin (IVIg) and subcutaneous immunoglobulin (SCIg). To enable patients with CIDP and who have been prescribed Hizentra® to administer SCIg competently and confidently in the home setting, the CSL Behring CARES™patient support program, (managed by independent provider, Aesir Health) was made available. An analysis of the first cohort of patients is presented here.

Method Assessment of the program via patient competency in SCIg self-administration.

Results 110 patients with CIDP enrolled in CARES™, ranging from 22 – 90 years old. Average weekly dose of 17.4 g of Hizentra® and overall average dose/kg of 0.22g was administered). Three patients were administering their weekly dose over 2 infusion sessions. Most patients were switched to SCIg following stabilisation with IVIg (2 exceptions commenced on SCIg pre-NBA funding; 1 enrolled from a clinical trial). Initial training session(s) were either via treating hospital or directly from Aesir Health nurses in-home. On average, patients became competent in home self- administration after 1.9 visits (Range,1–9).

Conclusion A broad age group of patients with CIDP are suitable for home-based therapy with Hizentra®. These patients can be effectively transitioned from hospital-based Ig treatment, to weekly home-based therapy with Hizentra® using the CSL Behring CARES program to help them confidently and competently transition. Further analyses of CARES are planned that will determine how to best continue to support patients with their ongoing home-based treatment.

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2425 REVISITING THE DIAGNOSIS OF CEREBRAL PALSY – WHEN, WHERE AND WHY?

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Objective Argument for complete diagnosis and separating by aetiology.

Cerebral Palsy (CP) has been an umbrella term capturing persons with motor development problems traceable to prenatal and perinatal insults to neurodevelopment. Apt arguments are made for 'splitting' and 'lumping' diagnostic labels in CP.

A 46 y/o female with Congenital Rubella Syndrome (CRS) presented, post head-strike, with imaging that revealed a prenatal right parietal infarct, and colpocephaly. She exhibited a smaller, spastic, right upper limb, bilateral congenital deafness, different partial colour to the right iris. She had intellectual impairment.

She fulfilled the criteria for monoplegic CP.

As new details of neurodevelopmental processes emerge, the original concept of CP (1843, Little; Osler; Freud), with minor modifications since that time, warrants close reflection.