

patients. Multiple domains of autonomic nervous system may be affected. A more comprehensive, accurate yet accessible test battery is required to better evaluate autonomic impairment in iRBD patients.

REFERENCE

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INTRALABYRINTHINE HAEMORRHAGE: AN IMPORTANT CAUSE OF ACUTE VERTIGO PRESENTING SIMULTANEOUSLY WITH SUDDEN HEARING LOSS

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Introduction Intralabyrinthine haemorrhage is a rare cause of sudden sensorineural hearing loss (SNHL) associated with an acute vestibular syndrome (AVS).

Case Report A 45-year-old female with a history of stable migraine with aura, presented with an AVS with simultaneous sudden SNHL and tinnitus without preceding viral symptoms. Examination revealed a positive left bedside head impulse test and left SNHL. Pure tone audiometry (PTA) revealed profound left SNHL. Video head impulse testing revealed significantly reduced vestibular-ocular reflex gain with catch-up saccades of the left posterior semicircular canal. Comprehensive vestibular testing revealed widespread left vestibular failure. Blood evaluation revealed mild lymphopenia but normal coagulation studies, inflammatory markers, vasculitic, autoimmune and pro-thrombotic testing. Computed tomography angiogram of head and neck and magnetic resonance imaging (MRI) brain with diffusion-weighted imaging (DWI) performed within 24-hours of symptom onset were normal. MRI of the internal auditory meatus (IAM) on day 7 revealed increased T1 and fluid-attenuated inversion recovery (FLAIR) signal in the left cochlea and semicircular canals, with no post-contrast enhancement. She was initially treated with oral prednisolone and valciclovir. Intratympanic steroids were given at 2, 3 and 4 weeks. Vestibular symptoms had improved by day 7 but at her 3-months follow-up she remained profoundly deaf in that ear and will be evaluated for cochlear implant candidacy.

Conclusion Identifying patients having an intralabyrinthine haemorrhage in the context of an AVS is important as it carries a poor prognosis. All patients with acute vertigo with sudden SNHL should be considered for urgent MRI of the labyrinth.

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THE VALUE OF CONCURRENT ELECTROCARDIOGRAPHY WHEN PERFORMING AN ELECTROENCEPHALOGRAPH

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Introduction The use of concurrent, single lead electrocardiograph (ECG) recording, when performing a routine electroencephalograph (EEG), has been standard practice for many

years. The diagnostic utility of a concurrent ECG is relatively unknown. Previous studies have reported its usefulness in syncope and the detection of newly identified cardiac dysrhythmia but have relied on specialist cardiologist interpretation of the ECG trace. This study expands the understanding of concurrent ECG and provides demographic information regarding the incidence, nature and diagnostic utility of ECG interpretation, during routine EEGs, as evaluated by neurologists.

Methods A single center, retrospective study of routine concurrent EEG and ECG recordings was performed. All routine EEGs, performed over one year, were analysed. Demographic data, underlying comorbidities, reasons for referral and ECG changes were assessed.

Results ECG abnormalities were identified in 147 (13.5%) of concurrent ECG/EEG routine recordings. The presence of ECG abnormalities was significantly associated with the reason for referral, namely being assessed for the evaluation of seizure activity and with increasing patient age. Thirty-eight patients (3.5%) had newly identified ECG abnormalities, of which atrial fibrillation (AF) (12 patients) and sinus bradycardia (9 patients) were the most common. Five patients (0.5%) had a change in their management consequent to the identified ECG changes.

Conclusions These findings support the value of neurologists' interpretation and need for ongoing concurrent ECGs, during routine EEG recording. The study raises concern about the requesting clinician's response to the identification of newly diagnosed cardiac dysrhythmias.

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VARICELLA ZOSTER VIRUS RHOMBENCEPHALOMYELITIS: A CASE REPORT

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Objectives Varicella Zoster Virus (VZV) can cause a spectrum of neurological presentations.

Methods Case report.

Results We describe the case of a 66 year old immunocompetent male who presented with a 2 day history diplopia and left sided ataxia on the background of a recent left facial VZV infection, presenting with vesicular rash and dysesthesia in the left trigeminal V2 and V3 distributions. Examination revealed a left internuclear ophthalmoplegia with skew deviation, left hemifacial numbness and tandem gait instability. CSF protein was elevated. Facial swab was VZV PCR positive. CT Angiogram revealed no intracranial stenosis suggestive of a vasculopathy. 1.5 T MRI Brain and Spine revealed high T2 signal in the dorso-lateral pons, medulla and adjacent upper cervical cord in the trigeminal nuclei. Smaller foci were also present in the left facial colliculus and in the right inferior cerebellar peduncle reflective of a rhombencephalomyelitis. Antiviral therapy was administered for 2 weeks. Follow up 3 T MRI at 5 weeks post discharge additionally revealed high T2 signal along the course of the left trigeminal nerve in the brainstem as well as high T2 signal and enhancement in the cisternal segment of the left trigeminal nerve. There was clinical improvement in all neurological symptoms over a 3 week period.

Conclusion This case demonstrates that VZV can result in a broad inflammatory process across the neuraxis and cause a