rhombencephalomyelitis in immunocompetent adults. MR imaging can confirm brainstem involvement.

2440 SACUBITIRIL/VALSARTAN INDUCED SYMPTOMATIC MYOCLONUS: A CASE REPORT

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Objective Drug induced myoclonus has been identified in number of medication classes. We describe a case of drug induced myoclonus from a newly marketed novel combination medication angiotensin receptor-neprilysin inhibitor Sacubitril/Valsartan (Entresto®), indicated for heart failure.
Methods A case report.
Results A 75 year old independent male presented with 11 hours of head and upper limb sudden onset myoclonic activity on the background of known history of heart failure having commenced Sacubitril/Valsartan one month prior and recently dose escalated. There was no inter-current illnesses and no other drug changes. Examination revealed an involuntary, irregular intermittent myoclonic activity in bilateral arms and head. Vital signs were normal. There was no acute abnormality on CT Brain or baseline blood tests. EEG showed marginal slowing in the right central region and no electrical correlate for the myoclonus. Following cessation of the Sacubitril/Valsartan the patient's myclonus abated within 36 hours and the patient was discharged home with no further complication.
Conclusion Myoclonus and other involuntary movements have been reported with the use of Sacubitril/Valsartan with onset ranging from hours to days in patients with similar medical profiles.[1] Similar side effects have been seen in rodent models but not in primates, and no clear pharmacological mechanism exists at this stage. We present this case to inform other clinicians of the potential serious neurological side effect of this increasingly used medication.

REFERENCE

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2441 MRI TRACTOGRAPHY IN MILLS SYNDROME: A CASE REPORT

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Objectives Mills syndrome is a rare isolated and asymmetrical upper motor neuron (UMN) syndrome.[1]
Methods A case report.
Results A 51-year-old presenting with a 5-year history of progressive right sided pyramidal weakness and spasticity. Although no cognitive symptoms were reported, the patient exhibited executive dysfunction on formal testing. Examination revealed right sided facial asymmetry as well mild pyramidal weakness in the upper and lower limbs but associated with prominent UMN features including spasticity, brisk reflexes and a positive right sided Hoffman's sign. Sensory examination was normal and there were no definite extrapyramidal signs or apraxia. Nerve conduction studies and electromyography demonstrated absence of denervation and large fibre neuropathy in clinically affected right sided muscles. Transcranial magnetic stimulation demonstrated an inexcitable left sided motor cortex. MRI Brain showed global atrophy with asymmetry in the left frontotemporal region. Cerebral PET revealed diffuse reduction in metabolism in the frontal cortex, more marked on the left and to a lesser degree in the parietal and temporal lobes bilaterally. CSF studies were bland. T-tau, P-tau and Abeta1–42 were not elevated. Genetic testing was negative for c9Orf72. 3T-MRI Tractography of the brain demonstrated asymmetry in cortical spinal tract fibres with significant reduction in left white matter fibre density. A clinical diagnosis of Mills syndrome was made. The patient received treatment with muscle relaxants and physical rehabilitation.
Conclusion Mills syndrome is a diagnosis of exclusion requiring multimodal investigations. Novel structural imaging such as the use of MRI Tractography can aid in the diagnosis of Mills syndrome.

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2442 CENTRAL PONTINE MYELINOLYSIS WITHOUT HYPONATREMIA IN LATE-STAGE PREGNANCY

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Introduction Central Pontine Myelinolysis (CPM) is a demyelinating disorder affecting the central pons linked to osmotic stress and hyponatremia. Cases in pregnancy have been associated with hyperemesis gravidarum, but also with other fluctuations in electrolyte and metabolic balance.[1]
Case A 22-year-old lady presented at 34 weeks (G2P0) with severe headache. Pregnancy to that date had been unremarkable and a detailed neurological examination was unremarkable. A MRI was performed revealing a central pontine lesion demonstrated by hyper-intensity on T2 and FLAIR imaging with hypo-intensity on T1 sequences, associated with significant diffusion restriction consistent with osmotic demyelination. Serum sodium level was normal at 136 mmol/L and remained so throughout her pregnancy with no other electrolyte imbalance noted.

A differential diagnosis of inflammatory, infective and ischaemic insult amongst others was considered. A spinal MRI was unremarkable and a lumbar puncture revealed a normal cell count, protein and glucose, with no oligoclonal bands. Blood pressure was controlled throughout pregnancy, and serological testing of serum FLT1/PIGF ratio did not reveal any early pre-eclampsia. The patient subsequently had a successful vaginal delivery at 36+1/40 weeks after induction of labour.

A repeat MRI performed 3 months after delivery demonstrated almost complete resolution of the pontine signal intensity with no further diffusion restriction.
Conclusion This case highlights a unique presentation of a central pontine myelinolysis in late-stage pregnancy without