

respectively). During baseline, median seizures *per day* on seizure diaries were 2.6 (IQR:1.4–5), compared with 284 (IQR:120.5–360) electrographic seizures *per day*, confirming that diaries capture only a fraction of seizure burden.

Conclusions Changes in GPFA within an individual may allow estimation of diary-recorded treatment response in participants undergoing DBS. When seeking to optimise treatment in patients with LGS, monitoring changes in the burden of GPFA may allow more rapid adjustment of treatment parameters, than relying on feedback from seizure diaries.

2346

COMPARISON OF NEUROLOGICAL OUTCOMES AMONGST PATIENTS WITH MILD STROKES WHO RECEIVE HYPERACUTE THERAPIES VS PATIENTS WITHOUT HYPERACUTE THERAPIES

^{1,2}Chris Kwan*, ^{1,2}Namrata Sobarun, ¹Jon Reimers, ^{1,3}Helen Brown. ¹Department of Neurology and Stroke, Princess Alexandra Hospital, Woolloongabba, QLD, Australia; ²Department of Neurology, Gold Coast University Hospital, Southport, QLD, Australia; ³Department of Neurology, Royal Brisbane and Women's Hospital, Brisbane, QLD, Australia

10.1136/bmjno-2022-ANZAN.20

Objectives Current guidelines recommend Endovascular Thrombectomy (EVT) for patients with strokes with large vessel occlusion (LVO) and NIHSS \geq 6, and thrombolysis for patients with NIHSS \geq 4 and in mild strokes with disabling symptoms.^{1–3} Patients with LVO and NIHSS \leq 6 are considered mild, yet 1 in 4 patients can deteriorate neurologically, miss out on hyperacute reperfusion therapies and have poor outcomes.^{4–5}

The aim is to compare neurological outcomes in patients with strokes with LVO and NIHSS \leq 6 who present within 24 hours of symptom onset to hospital, and who receive EVT with or without thrombolysis, thrombolysis alone, and no hyperacute therapy.

Methods This was a retrospective review of patients admitted to the Princess Alexandra Hospital's Stroke Unit between July 2018 and April 2021 with initial NIHSS $<$ 6. Data included NIHSS (arrival, 24 hours post-admission, discharge and Day 90), and Day 90 mRS. Data was collected and analysed with Microsoft Excel 2019 and IBM SPSS Statistics 27 by Chi-Square analysis.

Results 85 patients were included. 17 received EVT with or without lysis, 23 received lysis alone, and 45 received no hyperacute therapy. There was no difference in rates of clinical deterioration (NIHSS increase \geq 4) in 24 hours ($p=0.19$), on discharge ($p=0.37$) and by Day 90 ($p=0.63$).^{6–8} There was no difference in rates of good (mRS $<$ 3) and excellent (mRS $<$ 2) outcomes by Day 90 ($p=0.38$ and $p=0.34$ respectively).^{6–8}

Conclusions In mild strokes, there was no significant difference in neurological deterioration by 24 hours, discharge, and Day 90, and no difference in Day 90 mRS in all treatment groups.

REFERENCES

1. Lees KR, Bluhmki E, von Kummer R, Brodt TG, Toni D, Grotta JC, *et al.* Time to treatment with intravenous alteplase and outcome in stroke: an updated pooled analysis of ECASS, ATLANTIS, NINDS, and EPITHET trials. *Lancet.* 2010;**375**(9727):1695–703.
2. Ma H, Campbell BCV, Parsons MW, Churilov L, Levi CR, Hsu C, *et al.* Thrombolysis guided by perfusion imaging up to 9 hours after onset of stroke. *N Engl J Med.* 2019;**380**(19):1795–803.

3. Powers WJ, Rabinstein AA, Ackerson T, Adeoye OM, Bambakidis NC, Becker K, *et al.* 2018 guidelines for the early management of patients with acute ischemic stroke: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. *Stroke.* 2018;**49**(3):e46–e110.
4. Goyal M, Menon BK, van Zwam WH, Dippel DW, Mitchell PJ, Demchuk AM, *et al.* Endovascular thrombectomy after large-vessel ischaemic stroke: a meta-analysis of individual patient data from five randomised trials. *Lancet.* 2016;**387**(10029):1723–31.
5. Powers WJ, Rabinstein AA, Ackerson T, Adeoye OM, Bambakidis NC, Becker K, *et al.* Guidelines for the early management of patients with acute ischemic stroke: 2019 update to the 2018 guidelines for the early management of acute ischemic stroke: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. *Stroke.* 2019;**50**(12):e344–e418.
6. Rajasee V, Kidwell C, Starkman S, Ovbiagele B, Alger JR, Villablanca P, *et al.* Early MRI and outcomes of untreated patients with mild or improving ischemic stroke. *Neurology.* 2006;**67**(6):980–4.
7. Coutts SB, Modi J, Patel SK, Demchuk AM, Goyal M, Hill MD. CT/CT angiography and MRI findings predict recurrent stroke after transient ischemic attack and minor stroke: results of the prospective CATCH study. *Stroke.* 2012;**43**(4):1013–7.
8. Campbell BCV, Mitchell PJ, Churilov L, Yassi N, Kleinig TJ, Dowling RJ, *et al.* Effect of intravenous tenecteplase dose on cerebral reperfusion before thrombectomy in patients with large vessel occlusion ischemic stroke: the EXTEND-IA TNK part 2 randomized clinical trial. *Jama.* 2020;**323**(13):1257–65.

2211

A RATIONAL CLINICAL APPROACH TO THE DIAGNOSIS OF TRANSIENT ISCHAEMIC ATTACK AND ASSOCIATED MIMICS

¹Stephen Bacchi*, ²Rudy Goh*, ³Lydia Lam*, ⁴Peta Toner, ⁴Gill Dowie, ⁴Timothy Kleinig, ⁴Jim Jannes. ¹Southern Adelaide Local Health Network, Adelaide, SA, Australia; ²Northern Adelaide Local Health Network, Adelaide, SA, Australia; ³University of Adelaide, Adelaide, SA, Australia; ⁴Central Adelaide Local Health Network, Adelaide, SA, Australia

10.1136/bmjno-2022-ANZAN.21

Objectives The study was performed to identify the individual clinical features and risk factors most strongly associated with the diagnosis of a cerebrovascular cause to transient neurological symptoms (TIA, retinal ischaemia or stroke), as compared to common TIA mimics (including migraine and seizure).

Methods In a retrospective cohort study, all patients presenting with transient neurological symptoms to TIA clinics in Royal Adelaide Hospital and The Queen Elizabeth Hospital (tertiary hospitals) over a two-year period (2019–2020) were included. Clinical features and risk factors were recorded with a standardised form.

Results 1,273 individuals were included. From General Practitioner referrals, the prevalence (estimate of pre-test probability) of a cerebrovascular cause was 25.7% (66/257). From Emergency Department referrals the prevalence was 25.0% (225/899). For individuals with a diagnosis of stroke, the three features with the highest positive likelihood ratio (PLR) were an ABCD2 score of 5 (4.5, 95%CI 3.2–6.2), a past history of peripheral vascular disease (3.3, 95%CI 1.6–6.4) and the presence of limb weakness (3.3, 95%CI 2.7–4.1). These features also had the greatest PLR for a cerebrovascular aetiology (TIA, stroke, or retinal ischaemia). Clinical features that had low PLR for a cerebrovascular cause included positive visual phenomena, memory disturbance (0.2, 95%CI 0–0.45), transient generalised weakness (0.35, 95%CI 0.08–0.79) and confusion (0.35, 95%CI 0.08–0.80).

Conclusions This study demonstrated that specific clinical features and risk factors may be used to distinguish the aetiology of presentations with transient neurological symptoms, that are referred to TIA clinics from General Practitioner and Emergency Department settings.