describe the case of a 75 year old female who was diagnosed with an AOP stroke after presenting with the triad of altered level of consciousness, memory deficits and vertical gaze palsies.

Results A CT brain and angiogram showed a right P1 segment occlusion. The CT perfusion scan showed a focal area of mildly increased time to peak within the left PCA territory without corresponding cerebral blood flow or volume abnormality. Subsequent MRI revealed DWI hyperintensity with corresponding ADC hypointensity in the bilateral anteromedial thalamus with corresponding T2 FLAIR hyperintensity consistent with an AOP stroke.

Conclusion Knowledge of AOP stroke is important as it is a differential for patients presenting with an abrupt reduction in their level of consciousness. The syndrome is a diagnostic challenge and overlooking it can lead to delays in the provision of hyperacute therapies. CT perfusion is a low spatial resolution study with poor sensitivity for strokes of the deep grey nuclei as these tend to be small. AOP stroke is a mimicker of rostral brainstem stroke (a.k.a 'top of the basilar syndrome'). Therefore if basilar artery patency is observed in a patient despite suggestive symptoms, AOP stroke should be considered. Thalamic perforating branches are rarely visualised on CT angiography because of their narrow diameter therefore an AOP stroke must be inferred.

2606 PREDICT: PREEMPT FIXED-DOSE, FIXED-SITE AND FOLLOW THE PAIN

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Objective Analyse the real-world effectiveness and safety of 155U, 156–195U and 195U onabotulinumtoxinA in patients with chronic migraine (CM) from the PREDICT study.

Methods PREDICT (NCT02502123) was a Canadian 2-year, prospective, observational study in adults with CM. Patients received onabotulinumtoxinA approximately every 12 weeks (≤7 treatment cycles [Tx]). The primary endpoint was mean change from baseline in Migraine-Specific Quality of Life (MSQ) at Tx4. Headache days and physician and patient satisfaction were evaluated throughout. This analysis stratified the safety population (≥1 dose) into 3 groups (155U,156–195U and 195U) by the dose received on ≥3 of the first 4 treatment cycles.

Results 184 patients received ≥1 onabotulinumtoxinA dose, 68 received 155U, 65 received 156–195U and 13 received 195U on ≥3 treatments. Baseline characteristics were similar between groups. Baseline mean (SD) headache days/month 21.6(6.4) 155U; 20(7) 156–195U; and 21.7(6) 195U decreased over time (Tx4: -7.1[6.7] 155U; -6.5[6.7] 156–195U; -11.2 [6.4] 195U versus baseline). All MSQ domains improved in all groups at Tx4 and at the final visit. Physicians rated most patients as improved, and most patients were satisfied at final visit (80.8% 155U; 83.6% 156–195U; 90% 195U). Treatment-emergent adverse events (TEAEs) were reported in 18/68 patients (26.5%) in 155U, 41/65(63.1%) in 156–195U and 10/13(76.9%) in 195U; treatment-related TEAEs were 9 (13.2%), 10(15.4%) and 3(23.1%) respectively; serious TEAEs were 0, 3(4.6%) and 1(7.7%), none were considered treatment-related.

Conclusion Consistent with PREEMPT trials and REPOSE observational study, long-term treatment with onabotulinumtoxinA in PREDICT was safe, well-tolerated, and effective in CM. No new safety signals were identified.

2608 COVID-19 IN A SINGLE-CENTRE COHORT OF PATIENTS WITH MULTIPLE SCLEROSIS: NO DEATHS AND ONE ADMISSION

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Objectives An understanding of the outcome of patients with multiple sclerosis (MS) who contract COVID-19 is evolving. They may be at higher risk of more severe infection as they are frequently immunosuppressed due to treatment with disease-modifying therapies. This study describes outcomes of a MS patient cohort after COVID-19 infection.

Methods We maintained a prospective database of all patients with MS at Austin Health who reported COVID-19 infection between November 2021 and February 2022. We report relevant demographics, concurrent disease-modifying therapies, and outcomes including hospitalisation and mortality.

Results COVID-19 infection was reported by 50 patients. The median age was 37 (IQR 31–46), 37 patients (67%) were female. The cohort comprised 46 patients with relapsing-remitting MS, three with primary progressive MS, and one with secondary progressive MS. The majority of patients (84%) were on treatment with a disease-modifying therapy and 39 patients (78%) had received at least one dose of COVID-19 vaccination prior to infection. There were no deaths and one acute hospital admission. None have since reported symptoms consistent with long-COVID.

Conclusions In this single-centre cohort of patients with multiple sclerosis and COVID-19 infection, there was an excellent outcome despite high rates of immunosuppression. This suggests vaccinated patients with multiple sclerosis may not be at high risk of poor outcomes. Larger observational studies are recommended to provide more conclusive data.

2610 RESUSCITATION ORDERS DEMONSTRATE DIFFERENCES BY GENDER, STROKE TYPE AND INTERVENTION

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Objectives Resuscitation orders describe individual preferences and types of intervention, such as suitability for cardiopulmonary resuscitation (CPR), that may provide benefit in the event of critical deterioration. The purpose of this study was to examine stroke inpatient resuscitation order completion and content.

Methods This retrospective cohort study examined resuscitation orders in consecutive individuals admitted to a tertiary stroke centre over a 21-month period. Multivariable logistic regression was used to identify factors associated with resuscitation order completion and content.
Results 1924 individuals were included in the study. The proportion of individuals who had resuscitation orders completed was 37.4%. Several factors were associated with an increased likelihood of resuscitation order completion including having received endovascular thrombectomy (p=0.013) and having intracerebral haemorrhage (p=0.001). Females were more likely to have a resuscitation order that is not for CPR (p=0.021, OR 95%CI 1.080–2.542). Patients with intracerebral haemorrhage were also more likely to be not for CPR (p=0.037, OR 95%CI 1.039–3.353).
Conclusions Disparities exist in resuscitation order completion and content based on demographic and stroke characteristics. Further research is required to identify the reasons for these differences and to optimise resuscitation order completion.

2611 DYSKINESIA SIGNS AND SYMPTOMS, AND QUALITY OF LIFE IN PARKINSON'S DISEASE: POST HOC ANALYSIS FROM THE DYSCOVER STUDY

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Introduction This study assesses correlations of 'On' time without troublesome dyskinesia (TSD) and dyskinesia with health-related quality of life (HRQoL), activities of daily living (ADL), and Clinical Global Impression of Severity (CGI-S) and Change (CGI-C) among patients with advanced Parkinson's disease (aPD).
Methods In the phase 3b, multicenter, randomized, open-label DYSCOVER (DYSkinesia COmparative interventional trial on Duodopa VERsus oral medication) study (NCT02799381), patients with levodopa-responsive aPD and a Unified Dyskinesia Rating Scale (UDysRS) Total Score $\geq$30 received 12 weeks of optimized medical treatment or levodopa-carbidopa intestinal gel (randomized 1:1). This post hoc analysis combines data from both groups using Pearson correlation coefficients for baseline and change to week 12.
Results Among patients (n=60), there were significant moderate positive correlations between UDysRS and HRQoL (8-item Parkinson's Disease Questionnaire [PDQ-8]), ADL (Unified Parkinson's Disease Rating Scale part II [UPDRS II]), CGI-S (baseline), and CGI-C (week 12) at baseline and for change to week 12. There were significant moderate negative correlations between changes to week 12 in 'On' time without TSD and PDQ-8, UPDRS II, and CGI-C, and a weak negative correlation with PDQ-8 at baseline. Baseline 'On' time without TSD was not correlated with baseline UPDRS II or CGI-S. All change from baseline correlations were stronger than baseline correlations. Safety was consistent with the established LCIG safety profile, as reported previously.
Conclusion Dyskinesia signs/symptoms were moderately correlated with ADL, HRQoL, and CGI, while 'On' time without TSD was mostly negatively correlated, indicating a relevant impact on patients with high dyskinesia burden.

2612 INAPPROPRIATE CODE STROKE ACTIVATION: COSTS AND POTENTIAL HARM

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Objectives Urgent mobilisation of the stroke team via 'code stroke' processes instigates rapid stroke clinical and neuroimaging assessment to identify individuals who would benefit from hyperacute stroke reperfusion therapy (as well as intracerebral haemorrhage treatments).[1] Inappropriate code stroke activation may be associated with significant financial costs, opportunity costs and the potential for harm.
Methods The Medicare Benefits Schedule and SA Health Enterprise Agreements were utilised to determine code stroke related costs. A review of potential harm associated with inappropriate code stroke activation was conducted.
Results Inappropriate code stroke activation costs $371.45 per event in South Australia. Apart from cost related implications, it may delay the diagnosis of time-sensitive non-stroke differential diagnoses. It may also exacerbate certain stroke mimics such as cervical spine injury, humerus or neck of femur fractures. Code stroke imaging may confer both radiation and iodinated contrast related risks. Patients may also be investigated against their wishes in the hyperacute setting. In smaller centres with limited medical imaging capabilities, inappropriate code stroke activation may delay imaging of other patients with critical conditions. As the code stroke process is time consuming and involves multiple medical staff, it may also limit the volume of services provided to other patients.
Conclusions Due to these potential costs and harms, inappropriate code stroke activation should be minimised, while still appropriately and swiftly detecting and treating patients requiring hyperacute stroke intervention. Ongoing quality improvement processes may include auditing of inappropriate code strokes and follow-up education.

REFERENCE

1. Gomez C, Malkoff M, Sauer C, Tulyapronchote R, Burch C, Banet G. Code stroke. An attempt to shorten inhospital therapeutic delays. *Stroke*. 1994;**25**:1920–3.

2613 REVERSIBLE CEREBRAL VASOCONSTRICTION SYNDROME POST-SARS-COV-2 INFECTION

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Objectives We describe a case of delayed onset Reversible Cerebral Vasoconstriction Syndrome (RCVS) post-SARS-CoV-2 infection, an uncommon complication of acute SARS-CoV-2 infection.
Methods The participant was identified during admission for management of RCVS. The case was evaluated based on