**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

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## 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