

Objectives Primary results from the international ULIS-III study provided robust evidence for the benefit of repeated cycles of botulinum toxin-A (BoNT-A) for upper limb spasticity (ULS), with a (mean [95%CI]) cumulated GAS T-score of 49.5[49.1, 49.9] at 2 years. Internationally, patients with active function goals tended to require more frequent injection, and we hypothesized that reimbursement restrictions in Australia (which typically limited the number of injections received) may have adversely impacted outcomes compared with the total cohort.

Methods ULIS-III (NCT02454803) was a prospective, observational study following adults living with spasticity over 2 years of goal-directed ULS management including repeated BoNT-A treatment.

Results The Australian effectiveness subgroup included 115 patients (mean±SD age 53.8±16.9 years, 56% male, 79% stroke aetiology, median[IQR] duration of spasticity 5.3[15.6] years), of whom 74% had previously been treated with BoNT-A. Compared with the total cohort, Australian participants (N=82 treated with same brand) had fewer injection cycles (mean 2.7 vs 4.0), with longer injection intervals (331 vs 213) days. Mean[95% CI] overall cumulated GAS T-scores were lower at 47.9[46.4, 49.4] at 2 years. Under-achievement was particularly marked for active function goals (mean cumulated GAS-T-score 43.6 vs 46.6), while goals for passive function and pain ranged between 48.9–50.9, indicating achievement as expected.

Conclusions As anticipated, the Australian cohort had fewer injection cycles with longer injection intervals. Their overall goal attainment was lower, especially for active function goals. Amongst other possible factors, these data support the idea that restricted reimbursement may have impacted BoNT-A injection frequency, and consequently, patient outcomes.

2650 SPINAL EPIDURAL HEMATOMA FOLLOWING THROMBOLYSIS AS A STROKE MIMIC

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A 40-year-old Maori man presented to a rural hospital with syncope and a fall with head strike to the occiput. A non-contrast computed tomography (CT) of head and cervical spine excluded injuries. He was thrombolysed with Tenecteplase 50 mg for suspected ST elevation myocardial infarction (STEMI). He was transferred to the nearest tertiary hospital for coronary angiogram (CAG). He received intravenous bolus heparin 5000 units followed by continuous heparin infusion (25000 units) and 180 mg ticagrelor prior to transfer, and further intravenous heparin (2500 units) during CAG. The CAG suggested mild coronary artery disease only. Transthoracic echocardiogram was normal.

He developed mild asymmetric lower limb weakness following the CAG and a code stroke was activated. CT Brain, CT angiogram and CT cerebral perfusion were normal. Clinical examination the following day showed ataxic gait, absent lower limb reflexes and urinary retention with focal lower cervical tenderness. On revisiting the history patient reported blunt-force trauma to the neck during the fall. Urgent spinal magnetic resonance imaging (MRI) showed facet joint injury to mid-lower cervical spine with cord compression secondary

to epidural hematoma at the C5 level. Urgent surgical spinal decompression was undertaken. There was near complete resolution of neurological deficits at discharge following a short inpatient admission.

Spinal epidural hematoma is a rare significant complication following systemic thrombolysis¹. Anticoagulation and antiplatelets can have an additive effect. A careful history of trauma and close neurological observation can lead to early recognition and prompt treatment of this rare complication.

2651 COVID19-ASSOCIATED FOCAL RHABDOMYOLYSIS

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A 33-year-old, previously well, double-vaccinated female presented with two days of right leg pain following confirmed mild coronavirus disease (COVID19) four days prior. Initial examination revealed bilateral, right-predominant lower limb pyramidal weakness (Medical Research Council grade 3–4/5), absent right ankle jerk, bilateral flexor plantar reflexes and altered sensation in the right leg. She had urinary retention (700mls) and bruising over her right thigh. Incomplete transverse myelitis was first suspected, and she received 1g intravenous methylprednisolone for 3 days, but magnetic resonance imaging (MRI) spine and cerebrospinal fluid returned normal.

On day 5 of admission, she developed worsening right thigh pain and swelling (right thigh circumference was 12 centimetres more than left). Creatinine kinase was 75300 IU/L. Right lower limb doppler ultrasound excluded deep vein thrombosis. Electromyography showed no myogenic abnormalities. MRI right thigh showed widespread intramuscular myonecrosis with compression of the right sciatic nerve. She was managed with intravenous hydration, and daily monitoring of CK and renal function. The motor weakness and CK improved to normal over subsequent weeks.

Rhabdomyolysis has been previously reported in COVID19 infection in a small cohort of 10 unvaccinated patients with severe disease.¹ Autoimmune myocyte cross-reactivity has been postulated. Autopsy of psoas muscle and femoral nerve samples from 35 COVID19 patients showed inflammatory and immune-mediated damage but no evidence of direct viral invasion on light microscopy. This report demonstrates that rhabdomyolysis may occur in vaccinated patients with mild COVID19. The role of steroids in this situation is uncertain, although, our patient had a favourable outcome.

REFERENCES

1. Case Reports: Rhabdomyolysis Associated with COVID-19; *Am Fam Physician* 2020;**102**(11):645–648.

2653 CEREBRAL AIR EMBOLISM FOLLOWING LEFT ATRIAL APPENDAGE OCCLUSION PROCEDURE

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