Background Headache remains a major public health concern, with patients experiencing difficulty accessing optimal, evidence-based care.
Aim To evaluate gaps in education and training in headache amongst Neurology Advanced Trainees in New South Wales and Victoria.
Methods An eighteen-question survey was created using REDCap software. The survey was distributed to New South Wales and Victorian Neurology Core Trainees with a participation information sheet explaining the aims of the study, that participation was voluntary and that respondents would remain anonymous. Data were collected from Sept-October 2022.
Results The response rate was 30% (n = 22/77). Respondents comprised 50% first core year (AT1) and 50% second core year trainees (AT2). Amongst the respondents, 59% had less than 2 hours of exposure to headache education throughout their university degree and 69% had no exposure to headache clinics, and only 14% felt adequately prepared to manage headache disorders in either the outpatient or inpatient setting.
Conclusions Few neurology advanced trainees who responded to the survey felt adequately prepared to manage headache disorders in the inpatient or outpatient setting. Gaps in education and training were identified from medical school through to advanced training. Addressing these gaps is an avenue to optimize the management of headache disorders in Australia.

2716 A COMMON VISUAL COMPLAINT HERALDING UNDERLING MALIGNANCY

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Introduction Neurological complications of haematological malignancies are commonly reported. However, they are less frequently the presenting complaint. Neurological presentations of haematological disease are often difficult to localise and signs are complicated by treatments to treat possible differential diagnoses (McKee & Li, 2022). The Neurologist needs to be aware of these when faced with the complex undifferentiated patient.
Case Summary This report documents the diagnostic dilemma of a 78 year old male presenting with an atypical history of painful diplopia, headache and recurrent intermittent episodes of acute, severe pain affecting all four limbs proximally. Past medical history was significant for ischaemic heart disease and previous prostate cancer cured with radical prostatectomy. Investigations showed mildly raised ESR at 45mm/hr and neutropaenia (Neutrophils: 0.6 $x10^9$). Prostate Specific Antigen (PSA) was < 0.01ug/L. Due to temporal headache, visual symptoms and pain, treatment for temporal arteritis was initiated with prednisolone 1mg/kg/day. Temporal artery biopsy was normal and subsequent radiological investigations revealed a pituitary mass, widespread sclerotic bone lesions, and diffuse bone marrow uptake on nuclear scintigraphy. With a normal PSA, haematological processes were considered. While initial comprehensive computerised tomography was normal, following steroid cessation FDG-PET demonstrated widespread subcutaneous lymphadenopathy. Bone marrow biopsy confirmed diffuse large B cell lymphoma.
Conclusion This case raises the difficulty in neurological presentations of haematological disease and illustrates the dichotomy of symptomatic treatment and diagnostic accuracy. While neurologists are experienced in therapeutics for known malignant disease atypical, difficult to localise symptoms should necessitate sufficient investigation and consideration of systemic disease.

REFERENCE

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2717 HEADACHE WITH CONCURRENT EAGLE'S 'JUGULAR' SYNDROME, CONTRASTING OUTCOMES TO VASCULAR INTERVENTIONAL TREATMENT: A CASE SERIES

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Objective Eagle's 'jugular' syndrome is a rare cause of headache, related to an elongated styloid process impinging the internal jugular vein (IVJ) and altering dynamic intracranial pressure. This case series reports two cases of Eagle's 'jugular' syndrome and the use of a minimally invasive, vascular surgical technique as management.
Case The first case is of a 78 year old male with a two week history of bilateral retro-orbital pain that radiated into the neck and shoulders and was increased by turning the head. CT venogram and MRI venogram demonstrated bilateral IVJ stenosis with no other significant pathology. A staged bilateral IVJ stent was inserted and there was complete resolution of the pain. The second case is of a 49 year old with a 3 month history of bifrontal pain with temporal radiation. Photophobia, phonophobia and left facial numbness were also reported. No papilloedema was present but lumbar puncture opening pressure was 28 cm of water, with acellular CSF. CT venogram and MRI venogram demonstrated bilateral IVJ stenosis with no other significant pathology. A right IVJ stent was inserted. Whilst a post-procedure LP demonstrated a lower opening pressure of 20 cm, the patient reported no improvement in headache symptoms.
Conclusion With contrasting outcomes, these cases provide valuable insight into the criteria for diagnosis and treatment for patients suffering from headache due to Eagle's 'jugular' syndrome.

2720 TIA IN THE EMERGENCY DEPARTMENT: RATE OF SUBSEQUENT STROKE AND DIAGNOSTIC CORRELATION WITH NEUROLOGY OUTPATIENT CLINIC

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Background Data on the risk of stroke after a TIA is mostly derived before the era of routine upfront CT angiography and improved pharmacotherapies. Differences between emergency