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

[1]Molly Reynolds, [2]Alex Trussell*, [2]Dayna Griffiths. *[1]Department of Neurology, Concord Repatriation General Hospital, Concord, NSW, Australia*; *[2]Department of Neurology, Gosford Hospital, Gosford, NSW, Australia*

10.1136/bmjno-2023-ANZAN.109

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

1. McKee Z, Li Y. Unusual neurological presentations resulting in diagnosis of lymphoma in three patients. *RRNMF Neuromuscular Journal*, 2022;**3**(3):25–28, viewed 10 February 2023 https://journals.ku.edu/rrnmf/article/view/17930/16630

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

Jonathan Larach, Nicholas Halliwell*, John DG Watson. *Sydney Adventist Hospital, Wahroonga, NSW, Australia*

10.1136/bmjno-2023-ANZAN.110

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

Ross Cody*, Helen Dewey, Paul Buntine, Philip Choi. *Neurosciences, Eastern Health, Box Hill, VIC, Australia*

10.1136/bmjno-2023-ANZAN.111

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

department (ED) diagnosis of TIA and diagnosis in neurology outpatient clinic may alter these results.

Aims To assess the correlation between ED discharge diagnosis of TIA and neurology clinic diagnosis, and the risk of stroke after a TIA.

Methods Patients discharged from ED with a TIA diagnosis between 1st of July and 31st of October 2022 were included. Patients were followed-up at 30-days post-ED presentation by telephone, and medical records were reviewed at 90-days to ascertain neurologist diagnosis at clinic.

Results 70/128 (54.7%) patients were female, with a median age of 73. A neurologist agreed with the diagnosis of TIA in 21 of 108 patients reviewed in clinic (19.4%), with TIA a possible differential in another 17 (15.7%). 59 patients (54.6%) were felt unlikely to have had a TIA, and any new antithrombotic was ceased. 11 patients (10.2%) were re-diagnosed with having a minor stroke due to subtle persisting symptoms or MRI changes.

Four patients had a stroke within 90 days (3.1%). Two strokes occurred in patients with a neurologist TIA diagnosis, and one occurred in a patient with a diagnosis felt unlikely to be TIA. One patient who refused follow-up also had a stroke.

Conclusion The risk of stroke after discharge from ED with a TIA diagnosis appears stable despite improvements in imaging and pharmacotherapies. Further effort to improve diagnostic accuracy is needed.

2722 USE OF SUBCUTANEOUS IMMUNOGLOBULIN IN THE MAINTENANCE TREATMENT OF CIDP: A SINGLE-CENTRE EXPERIENCE

[1,2]Belinda Cruse*, [1]Shuk-Yin Tsang, [1]Edrich Rodrigues, [1,2]Lynette Kiers. *[1]Royal Melbourne Hospital, Parkville, VIC, Australia; [2]Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, Melbourne, VIC, Australia*

10.1136/bmjno-2023-ANZAN.112

Objectives To review treatment efficacy, side effects and satisfaction among chronic inflammatory demyelinating polyneuropathy (CIDP) patients treated at the Royal Melbourne Hospital with subcutaneous immunoglobulin (SCIg).

Methods We performed a chart review of all CIDP patients transitioned from intravenous immunoglobulin (IVIg) to SCIg from 2019–2022. Prior maintenance dose of IVIg, starting dose of SCIg, SCIg dose at the end of the reviewed period (or at discontinuation) and side effects are presented. Patients using SCIg in December 2022 were interviewed regarding satisfaction, side effects, ease of use, convenience of SCIg.

Results 5 patients transitioned onto SCIg, age range 50–72 years. Maintenance dose of IVIg ranged 0.34–1.7g/kg/month. SCIg was commenced at a mean ratio to IVIg of 1.08:1, administered weekly or twice weekly. At the end of the reviewed period, the SCIg dose had increased in 2 patients, decreased in one, and remained unchanged in 2 patients. No relapse in CIDP occurred during transition to SCIg. Functional outcomes improved in 2 and remained unchanged in 3 patients. One significant side-effect occurred with skin necrosis at injection sites in one patient leading to treatment discontinuation. Four patients were interviewed, all reported satisfaction with SCIg efficacy, ease and convenience of use, with no negative impact on daily activities. One patient had died of unrelated illness.

Conclusions SCIg therapy was effective, easy and convenient for all CIDP patients treated at our centre. Skin necrosis has been reported in association with SCIg use but appears to be extremely rare.

2723 SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS PATIENTS IN AUSTRALIA TREATED WITH SIPONIMOD; NOVEL REAL-WORLD EVIDENCE FROM THE MSGO DIGITAL SUPPORT PROGRAM

[1]Todd Hardy*, [2,3]Patrick Aouad, [1,4]Michael Barnett, [5,6]Stefan Blum, [7]Simon Broadley, [8]William Carroll, [9]Denis Crimmins, [10]Dayna Griffiths, [11]Suzanne Hodgkinson, [12,13]Jeannette Lechner-Scott, [14]Andrew Lee, [15]Ram Malhotra, [16]Pamela McCombe, [2,17]John Parratt, [18]Christopher Plummer, [19]Anneke van der Walt, [20]Kate Martel, [20]Rob Walker. *[1]Brain and Mind Centre, Camperdown, NSW, Australia; [2]Northern Clinical School, University of Sydney, Sydney, NSW, Australia; [3]Sharp Neurology, North Shore Private Hospital, St Leonards, NSW, Australia; [4]Royal Prince Alfred Hospital, Camperdown, NSW, Australia; [5]Faculty of Medicine, The University of Queensland, Brisbane, QLD, Australia; [6]Department of Neurology, Princess Alexandra Hospital, Woolloongabba, QLD, Australia; [7]School of Medicine, Gold Coast Campus, Griffith University, Southport, QLD, Australia; [8]Department of Neurology, Sir Charles Gairdner Hospital and Perron Institute, Nedlands, WA, Australia; [9]Central Coast Neurosciences Research, Erina, NSW, Australia; [10]Central Coast MS clinic, Gosford Hospital, Gosford, NSW, Australia; [11]Liverpool Hospital, Liverpool, NSW, Australia; [12]Hunter Medical Research Institute, University of Newcastle, New Lambton Heights, NSW, Australia; [13]John Hunter Hospital, Hunter New England Local Health District, New Lambton, NSW, Australia; [14]Flinders University College of Medicine and Public Health, Flinders Medical Centre, Bedford Park, SA, Australia; [15]Canberra Specialist Centre, Deakin, ACT, Australia; [16]University of Queensland, St Lucia, QLD, Australia; [17]Department of Neurology, Royal North Shore Hospital, St Leonards, NSW, Australia; [18]Centre for Neurosciences and Neurological Research, St Vincent's Hospital Melbourne, Fitzroy, VIC, Australia; [19]Department of Neuroscience, Central Clinical School, Monash University, Melbourne, VIC, Australia; [20]Novartis Pharmaceuticals Australia Pty Ltd, Macquarie Park, NSW, Australia*

10.1136/bmjno-2023-ANZAN.113

Objectives Siponimod is approved in Australia for adults with secondary progressive multiple sclerosis (SPMS). Pre-screen requirements for siponimod include CYP2C9 genotype testing. To support onboarding, a digital platform, 'MSGo', was developed by Novartis and RxMx® for Healthcare Professionals and their patients. Here, data derived exclusively from MSGo was utilised to characterise the onboarding experience of siponimod patients in Australia.

Methods The study enrolled >350 adults with SPMS registered in MSGo for siponimod in Australia. The primary endpoint was average time for onboarding with key secondary endpoints addressing adherence and variables that influence onboarding and adherence.

Results Final data extraction on April 20, 2022 included 368 patients (median age 59y). CYP2C9 genotype testing took a median of 19 days (95%CI 17–21) from registration. Mixture-cure modelling estimated that 58% of patients will ever initiate siponimod, with a median time to initiation of 56d (95%CI 47–59) from registration. Self-reporting of daily treatment had a drop-off of ~25% after the first week of initiation. A continued decline in reporting over time limited assessment of adherence. An important role of care partners was identified, with Cox regression analyses demonstrating that SPMS patients who nominated a care partner were more likely to initiate (HR:2.1, 95%CI 1.5–3.0) and to continue self-reporting their daily medication (HR:2.2, 95%CI 1.3–3.7).

Conclusions This study provides insights into siponimod onboarding for adults living with SPMS in Australia and demonstrates the impact of MSGo and care partner support during a period challenged by the COVID-19 pandemic.