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

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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

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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.