2741 DENTAL PROCEDURE INDUCED CEREBELLAR HAEMORRHAGE WITH VISUAL TILT AND UNSUSPECTED CADASIL – CASE REPORT

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Abstract A man in his 60's complained of vertigo and 'vision tilt' following a dental procedure. A cerebellar haemorrhage and cerebral microbleeds (CMBs) were diagnosed on imaging. Subsequent testing revealed CADASIL (cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy). The role of the dental procedure as a trigger for intracerebral haemorrhage (ICH) is discussed.

Case A male in his 60s presented to emergency department after having two teeth extracted under local anaesthetics. Thirty minutes after the procedure he had a sudden onset of nausea, vomiting, dizziness, and visual changes such as rotation of objects 90 degrees anticlockwise direction.

On examination, there was left-sided nystagmus at extreme gaze. The gait was unsteady with the patient falling to the right side. There was mild incoordination of the left upper limb.

Urgent CT of the brain showed a left cerebellar haemorrhage adjacent to the 4th ventricle extending up to the wall of the ventricle. Further magnetic resonance imaging (MRI) of the brain showed a focal ovoid hematoma in the region of the left dentate nucleus with extensive punctate haemosiderin foci, predominantly involving the thalami, but also the pons and contralateral cerebellum as well as a few more peripherally located foci within the fronto, parieto and temporal cortices. Severe confluent periventricular and mild pontine leukoencephalopathy were also noted which likely represents small vessel ischemic changes. Genetic analysis was consistent with CADASIL diagnosis.

2743 REMISSION OF REFRACTORY PRIMARY ANGIITIS OF THE CENTRAL NERVOUS SYSTEM WITH INFLIXIMAB THERAPY – A CASE REPORT

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Introduction We report remission of refractory primary angiitis of the central nervous system (PACNS) with the use of infliximab.

Case A 29-year-old previously-well man presented with rapid onset of left-sided hemiplegia complicated with bilateral tonic-clonic seizures. Initial MRI brain imaging demonstrated leptomeningeal enhancement in the right frontoparietal region with T2/FLAIR hyperintensity. Biopsy of the lesion confirmed a granulomatous subtype of isolated PACNS. He was commenced on oral prednisolone 50mg daily that was weaned over 5 months. On prednisolone 15mg, he experienced radiological progression and mycophenolate was added. Further radiological activity and breakthrough focal seizures led to cessation of mycophenolate, increased prednisolone to 80mg and six monthly cycles of intravenous cyclophosphamide. Despite cyclophosphamide treatment, subsequent rituximab infusions and intravenous methylprednisolone, there continued to be clinical and radiological progression. Nearly 1.5 years after diagnosis, he was started on 5mg/kg of 8-weekly infliximab infusions with an oral prednisolone taper. Within 2 months of commencing infliximab, there were no further clinical symptoms and serial neuroimaging demonstrated no evidence of active disease. After 1 year of stability on infliximab therapy, during which prednisolone was successfully weaned, a patient-directed treatment pause was undertaken. Repeat imaging after 4 months demonstrated new enhancement. Infliximab was promptly restarted, leading to resolution of the MRI enhancement. The patient remains stable 2.5 years after commencement of infliximab.

Conclusion This report supports growing clinical evidence for the use of infliximab in refractory PACNS to obtain radiological and clinical remission. Further studies are needed to assess the optimal timing of infliximab use.

2746 DEVELOPING A QUALITY ASSURANCE FRAMEWORK FOR NEURO-OPHTHALMOLOGY USING THE NEURO-OPHTHALMOLOGY DATABASE (NODE)

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Objectives Quality assurance (QA) in neuro-ophthalmology (NOPH) is often lacking. We aimed to assess the quality of referral assessment and time-to-consult for common neuro-ophthalmological conditions by implementing a QA registry, NODE (Neuro-ophthalmology Database) in a tertiary Neuro-ophthalmology clinic. Australian standardised triage categories; P1 (consult<=30 days), P2 (consult<=30 to 60 days) and P3 (consult>60 days) were developed and validated for neuro-ophthalmological conditions.

Methods We collected data in NODE on 676 patients at Alfred Hospital, Melbourne and developed a consensus on the assignation of NOPH conditions to triage categories using a modified Delphi Approach with a panel of seven experienced neuro-ophthalmologists. We analysed the mean days from referral to triage, and from triage to initial consultation and compared these to the Australian standardised triage categories.

Results Common diagnoses were Idiopathic Intracranial Hypertension, IIH (19%), Optic Neuropathy, ON (14%), Non-specific Headaches, (11%) Cranial Nerve Defects, CND (8%) and Papilloedema (7%). The mean time from referral to triage was <5 days for all the common diagnoses. The mean days (±standard deviation (SD)) from P1 category triage to initial consult for IIH was 15 (±12), Acute ON 16 (±14), and CND was 20 (±15). For P2 triage-to-consult for Papilloedema was 20 (±19), non-specific Headaches was 22 (±20), and EOMD was 48 (±22). For P3 triage-to-consultant for Non-ocular Myasthenia Gravis was 38 days (±29) and for Visual Snow was 54 (±31 days).

Conclusions We established a NOPH registry that will serve as a framework to benchmark quality of care between NOPH services and improve clinical outcomes for patients.