cessation of seizures. He was discharged on weaning dose of prednisolone, maintenance IVIg, mycophenolate, and ASM. Ten months after cessation of immunotherapy, patient's mesothelioma continued to be stable.

Conclusion This case highlights the important role of immunotherapy in treating focal seizure secondary to ICI-induced AE. Interestingly, cessation of ICI therapy did not lead to tumor progression at 1 year follow-up in this case.

2758 A CASE LIKE NO UDDER

[1]Mina MB Botrous*, [2]Sumana SG gopinath. [1]*St George Hospital, Carlton, NSW, Australia*; [2]*Neurology, Campbelltown Hospital, campbelltown, NSW, Australia*

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A young patient with acute behavioural disturbance due to meningo-encephalitis of unclear cause. 38 year old butcher returned from work feeling generally lethargic and unwell. He woke up in the night pacing aimlessly around the house and developed non-specific tingling in the right leg and presented to the emergency department . A stroke code was initiated for focal deficits. The acute investigations were unremarkable including CT Brain and Angiogram. He was discharged home but represented 2 days later when his wife found him urinating on the bed at midnight without recollection of the events. No focal neurological findings on examination.MRI brain demonstrated leptomeningeal enhancement supratentorially bilaterally. Initial lumbar puncture demonstrated WCC >300 with predominately mononuclear cells. No organisms grown and CSF viral panel, fungal culture, AFB all negative. EEG demonstrated excessive slowing without any epileptiform discharges.Empiric cover for meningo-encephalitis commenced and IV Methylprednisolone for 5 days with an oral taper The limbic encephalitis panel was negative. Brucella IgM was low positive on serology and Flavivirus IgM positive but this was thought to be a possible false positive. CSF PCR for Brucella and Japenese encephalitis were negative. Completed 3 weeks of antimicrobials and a course of steroids with good clinical improvement.Notable features are the clinical/radiological findings compatible with meningo-encephalitis of unclear cause. The patient's occupation presented challenges due to the potential exposure to atypical organisms without clear diagnostic results.We discuss the importance of occupational exposure to potential CNS infections, and need to include uncommon pathogens in our diagnostic armamentarium.

2759 ADULT-ONSET ACUTE NECROTISING ENCEPHALITIS WITH BILATERAL HOMONYMOUS INCONGRUENT QUADRUPLE SECTORANOPIA

Jessica Redmond, Robert Hurford, Anthony Fok. *Department of Neurology, Royal Melbourne Hospital, Melbourne, VIC, Australia*

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Introduction Acute necrotising encephalopathy (ANE1) is a genetic predisposition related encephalopathy that can occur following influenza type A, parainfluenza or Human Herpes Virus 6 infection. It is commonly seen in children and associated with the autosomal dominant missense mutation in the RAN Binding Protein 2 (RANBP2) gene.[1–3]

Case A 45-year-old female with known RANBP2 mutation presented with coryzal symptoms, headache and blurred vision and tested positive to influenza A infection. RANBP2 was previously screened in our patient as her daughter developed ANE1 in childhood. Formal visual fields showed bilateral homonymous incongruent quadruple sectoranopia. Magnetic Resonance Imaging (MRI) Brain demonstrated T2 FLAIR bilateral lateral geniculate nucleus hyperintensities with foci of low susceptibility and diffusion restriction and was treated with intravenous methylprednisolone and plasma exchange. Follow-up showed MRI hyperintensities had reduced and the patient's visual fields improved. Optical coherence tomography (OCT) of the retinal nerve fibre layer (RNFL) and ganglion cell layer demonstrated corresponding thinning in the pattern of field defects consistent with retrograde degeneration.

Discussion We describe novel visual field defects secondary to bilateral thalamic lesions from influenzae A triggered ANE1. The wedge-shaped visual field defects are explained by the vascular topography of the thalamus and the incongruency is related to the anterior location of the visual pathway lesions.

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2760 MANAGING HYPOKALAEMIC PERIODIC PARALYSIS DURING PREGNANCY AND LABOUR: A CASE REPORT

Namrata D Sobarun*, Emily Watson*. *Princess Alexandra, Woolloongabba, QLD, Australia*

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Case Report Hypokalaemic periodic paralysis (HypoPP) is a rare inherited neuromuscular disorder characterized by intermittent episodes of focal or generalized weakness of skeletal muscle which can last hours to days, with concomitant hypokalaemia.[1] Pregnancy has been previously reported to exacerbate symptoms, however ideal management during pregnancy and labour is not well documented.[2]

We present a case of a 34-year-old woman with confirmed HypoPP secondary to a pathological variant in the SCN4A gene who surprisingly reported improvement in her symptoms during pregnancy, requiring minimal oral potassium supplementation. Significant care was taken to avoid known triggers, with a heavy emphasis on dietary modification. The patient went on to have a vaginal delivery at term, utilising spinal anaesthesia without complication.

This case highlights the importance of an individualized and multi-disciplinary approach when managing patients with rare neurological conditions such as HypoPP in the obstetric setting.

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