This case expands the spectrum of movement disorder-presenting steroid-responsive CNS autoinflammatory disease, emphasising seronegative case recognition. Myoclonus may be an initial manifestation of autoimmune encephalitis (CASPR2, $GABA_BR$, GlyR, DPPX, IGLON5, GFAP).[1] Anti-GFAP astrocytopathy is a radiological differential, although the pathogenicity of anti-GFAP antibodies is questionable and seronegative cases are increasingly reported.[2 3]

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3639 A COMPARATIVE STUDY OF NEUROLOGICAL OUTCOMES AFTER PROXIMAL HAMSTRING AVULSION INJURY AND SURGICAL REPAIR: DISTINGUISHING TRAUMATIC AND IATROGENIC CAUSES

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Background Complete avulsion injuries of the proximal hamstring, which necessitate surgical intervention, present challenges due to their close relationship with the sciatic nerve. This research aims to quantify the frequency and characteristics of neurological impairments following injury and surgical repair, differentiating between those caused by trauma and those resulting from the procedure itself. Currently, there is a lack of comprehensive neurophysiological studies on sciatic nerve damage in this region, and interpreting MRI findings in the affected muscles remains difficult.

Methods Eighteen patients with MRI-confirmed proximal hamstring avulsions underwent surgical reattachment. To monitor nerve injury progression, electromyography (EMG) and MRI assessments were conducted over a 12-month period. The primary objective was to determine the origin of nerve injuries, while secondary goals included evaluating their progression and linking findings to patient outcomes.

Results Among the 18 participants, 5 had nerve injuries before surgery, while 3 developed iatrogenic nerve damage afterward, almost exclusively in the hamstring muscles. SHORE scores did not show a significant difference between patients with normal versus abnormal EMG findings, though those with abnormal EMG exhibited a trend toward more neurological symptoms. Greater tendon retraction correlated with more severe EMG abnormalities in the hamstring muscles.

Conclusion Neurological involvement and recovery following proximal hamstring avulsion injuries vary among patients. MRI can aid in predicting nerve injury severity by measuring tendon retraction, with a nerve-at-risk distance (NARD) exceeding 5 cm suggesting a higher likelihood of neurotrauma. However, the long-term clinical effects of underlying nerve damage, particularly in athletes, warrant further research.

3641 BILATERAL MEDIAL MEDULLARY INFARCT

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Background Bilateral medial medullary infarction (MMI) is a rare and devastating stroke syndrome often involving progressive bilateral weakness, bulbar dysfunction, loss of deep tendon reflexes and respiratory failure.

Results A 70-year-old male presented to the emergency department with a two-day history of dysarthria, upper limb weakness and gait disturbance. Initial examination findings revealed bulbar weakness, hyporeflexia and generalised weakness. Over 24 hours he progressed to areflexic tetraplegia with severe respiratory failure requiring intubation and mechanical ventilation. CT non-contrast was unremarkable and contrast allergy precluded CT angiography and perfusion studies. Cerebrospinal fluid protein was elevated to 0.95g/L, and diagnosis of Guillain-Barre Syndrome was considered. Plasma exchange was commenced with no improvement in symptoms. Diffusion weighted MRI demonstrated a characteristic 'heart-shaped' area of restricted diffusion in the medial medulla in keeping with acute infarction.

Conclusion This case highlights (i) the diagnostic challenge associated with MMI given its propensity to mimic other common pathologies and (ii) the importance of rapid identification and treatment given its potentially devastating outcome.

3642 DOWN THE RABBIT HOLE: CASE REPORTS OF A HALLUCINOGEN-INDUCED DISORDER OF NEUROPERCEPTION

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Background/Objectives We present case histories of severe adverse effects associated with Hallucinogen Persisting Perception Disorder (HPPD), a disorder of neuroperception involving visual and other senses that is due to the treatment of various neuropsychiatric disorders with hallucinogens. This includes the case of a young woman who developed visual hallucinations of distorted shapes and colours after participating in a clinical trial of psilocybin for treatment-resistant depression. She continued to have ongoing perceptual abnormalities, and other neuropsychiatric phenomena with severe effects on her quality of life.

Objective To discuss the ramifications of HPPD stemming from treatment with psychedelics for neuropsychiatric disorders and the importance this holds for clinical practice and research trials.

Methods We present case histories of people with HPPD, with a focus on a case occurring during a research trial as well as a systematic review of HPPD occurring with therapeutic use of hallucinogens.

Results HPPD affects approximately 1 in 25 people taking psychedelics whether recreationally or therapeutically. HPPD occurs irrespective of dosing or frequency of use and may

occur in those who have microdosed. HPPD may have serious long-term consequences often associated with other perceptual and neuropsychiatric symptoms.
Conclusion HPPD is a potentially devastating adverse effect of hallucinogens irrespective whether the use occurs recreationally, therapeutically or even in a controlled trial. It is important that HPPD be screened for and that informed consent is obtained from patients with reference to this adverse effect. Patient education prior to being offered therapeutic hallucinogens is essential for clinical and research practice.

3643 RAPID-ONSET ACUTE MOTOR SENSORY AXONAL NEUROPATHY (AMSAN)

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Background/Objectives Guillain-Barre Syndrome (GBS) is a polyradiculoneuropathy with an acute-subacute onset. We present a case of AMSAN that reached symptom nadir within 12 hours of symptom onset.
Methods Case study and review of literature
Results A 39 year old male presented with acute onset weakness of all limbs, dysarthria and ptosis, without sensory involvement. This was preceded by a diarrhoeal illness 6 days prior.

Symptoms progressed rapidly, and within 8 hours of symptom onset he was intubated. Nerve conduction studies and electromyography on day 5 found diffusely absent motor and sensory responses, and negative repetitive nerve stimulation. His stool tested positive for Campylobacter and Shigella/E coli. He received intravenous immunoglobulin and subsequently 5 cycles of plasma exchange. Subsequently, his muscle and respiratory function slowly improved and he is rehabilitating in hospital.
Conclusion This case highlights the potential for GBS to progress rapidly, and the need for early intensive care involvement.

3644 ECHOES OF A SILENT CULPRIT: OVERSHADOWING MARANTIC ENDOCARDITIS AMIDST A PROTHROMBOTIC STORM

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A 57 year-old woman was admitted with acute dysarthria and dysphagia on a background of Sjogren's syndrome with triple-positive antiphospholipid syndrome (APLS) and metastatic endometrial cancer. She had incurred several thromboembolic events over three years including splenic infarct, pulmonary embolism, and in the final eleven months sustained three ischaemic MCA infarcts (each with successful thrombectomy). These events occurred despite therapeutic anticoagulation and hydroxychloroquine therapy. Hitherto the aetiology for her morbidity was attributed solely to APLS, as an unrevealing and singular index echocardiogram had been completed at the time of her first cerebrovascular accident.

This admission the patient underwent M1 endovascular thrombectomy, with an improvement in NIHSS from 11 to 2. Histopathology demonstrated platelet/fibrin-rich thrombus with low erythrocyte count. FBC revealed pancytopenia whilst coagulation times were normal with an elevated D-Dimer and non-consumed fibrinogen. Repeat assays for antiphospholipid antibodies were remarkably negative, however transthoracic echocardiography demonstrated a small echogenic mass on the anterior mitral leaflet with concomitant, new mild regurgitation. Blood cultures remained negative throughout admission.

Haematology input was sought before a diagnosis of marantic (non-bacterial thrombotic) endocarditis was made. Therapeutic enoxaparin was re-introduced 24 hours post-thrombectomy, and methylprednisolone pulse was initiated. Hydroxychloroquine was re-commenced, and the patient received a four-week course of rituximab. Three months later she remains on therapeutic enoxaparin without further thromboembolic events.

This case reminds us to consider marantic endocarditis as a cause of recurrent multi-territory infarcts with echocardiographic (but not microbiological) findings, and to avoid diagnostic overshadowing amidst systemic inflammation and malignancy.

3646 STATUS AMAUROTICUS: A RARE CASE OF FOCAL STATUS EPILEPTICUS ARISING FROM MIDLINE OCCIPITAL STRUCTURES

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Background Status amauroticus, or 'ictal blindness', is a rare neurological syndrome. It is typically unilateral, presenting with homonymous hemianopia. We describe a complete ictal blindness caused by focal status epilepticus from the midline occipital region.
Case An 83-year-old independent woman with metastatic cholangiocarcinoma presented after finishing a 5-fluorouracil infusion with acute onset complete blindness, confusion and dysarthria. She had experienced headaches and nausea in the preceding 24 hours, which she had attributed to chemotherapy. On examination, she had no perception of light in either eye. The pupils were 4 mm and reactive, with no relative afferent pupillary defect. There were no ocular abnormalities on the slit lamp examination. She was oriented to time and place but lacked insight into the gravity of her disability. The remainder of the neurological examination was normal. Laboratory markers demonstrated chronic anaemia (91 g/L), thrombocytopenia (95 x10^9/L), and a mildly elevated ESR (37 mm/hr). CT stroke series and MRI (performed ~4hr after symptom onset) were unremarkable. Her symptoms persisted over 72 hours, at which point a 20-minute EEG was performed, which demonstrated three focal seizures from the midline occipital region (O1=O2). She was loaded with levetiracetam and had a complete return of her vision within a few hours. The syndrome did not recur. Lumbar puncture and PET/CT to investigate for an underlying cause of the seizures were uninformative.
Conclusions We present a rare case of bilateral occipital focal status epilepticus manifesting as complete ictal blindness, with excellent resolution with antiseizure medications.