outcome, and dorsolateral and anterior cord lesions had a better prognosis.

Disclosure: Dr. Vorasoot has nothing to disclose. Miss Saichua has nothing to disclose. Miss Sirikarn has nothing to disclose. Mrs. Boonrod has nothing to disclose. Narongrit Kasemsap has nothing to disclose. Kannikar Kongbunkiat has nothing to disclose. Somsak Tiamkao has nothing to disclose.

Characterization of Neurosarcoid Myelitis and Assessment of Treatment Response: A Multicenter Retrospective Study

Denis Balaban, Giovanna Manzano, Ahya Ali, Eoin Flanagan, Allen Aksamit, Vyanka Redenbaugh, Stacey Clardy, Rohini Samudralwar, Paunel Agyei, Aram Zabeti, Robert Baughman, Bart Chwalisz, Michael Levy, Shamik Bhattacharyya

Objective

To determine if initial treatment with corticosteroids plus steroid-sparing immunosuppressive therapy (IST) results in faster gadolinium contrast-enhancement resolution in neurosarcoid myelitis (NSM) than corticosteroid monotherapy (CSM).

Background

Neurosarcoidosis is a rare cause of myelitis, treated initially with corticosteroids. Whether combination therapy of corticosteroids plus IST is more effective than CSM at disease onset is unknown.

Design/Methods

We retrospectively reviewed cases of definite or probable NSM, defined by Neurosarcoidosis Consortium Consensus Group, in adults treated at six United States centers. We characterized clinicoradiographic features and treatment outcomes after NSM diagnosis. Treatment groups were defined as CSM, corticosteroids plus intermediate oral IST (methotrexate or mycophenolate mofetil), corticosteroids plus highly effective IST (cyclophosphamide/TNF-alpha inhibitors), or corticosteroids plus other. We hypothesized that initial treatment with corticosteroids and IST would result in faster gadolinium contrast-enhancement resolution (primary end point).

Results

63 patients with NSM (32 female, 30 definite, median age 48) were identified. 86% had spinal cord enhancement on post-gadolinium T1 sequences (8% without enhancement, 6% without data). Time from symptom onset to treatment initiation varied from 11 days to 10 years (median 4 months). All but one patient received corticosteroids initially. 16/63 received corticosteroids alone. 29/63 received corticosteroids and subsequently IST (10 TNF-alpha inhibitor/cyclophosphamide, 10 mycophenolate/methotrexate, 9 other). Median time to IST initiation was 9.1 months (range 1–132). 16/63 were treated with initial IST (4 TNF-alpha/cyclophosphamide, 8 mycophenolate/methotrexate, 4 other). There was no significant difference in time to contrast-enhancement resolution between corticosteroids with/without subsequent IST versus corticosteroids + initial IST (Wilcoxon-rank sum test 0.93) or CSM versus corticosteroids + initial IST (Wilcoxon-rank sum test 0.97). Limitations are small sample size, variations in initiation of treatment and doses used, and intervals of clinical/radiographic follow-up.

Conclusions

Standardization of reporting and monitoring of treatment and outcomes is needed for patients with NSM to better assess optimal initial therapy plans.

Disclosure: The institution of Dr. Balaban has received research support from Biogen. Dr. Manzano has nothing to disclose. Dr. Ali has nothing to disclose. The institution of Dr. Flanagan has received personal compensation in the range of $500-$4,999 for serving on a Scientific Advisory or Data Safety Monitoring board for Alexion. Dr. Flanagan has received personal compensation in the range of $500-$4,999 for serving on a Scientific Advisory or Data Safety Monitoring board for Genentech. Dr. Flanagan has received personal compensation in the range of $500-$4,999 for serving on a Scientific Advisory or Data Safety Monitoring board for Horizon Therapeutics. Dr. Flanagan has received personal compensation in the range of $500-$4,999 for serving on a Speakers Bureau for Pharmacy times. The institution of Dr. Flanagan has received research support from Viela Bio. Dr. Flanagan has a non-compensated relationship as a Member of medical Advisory Board with The MOG Project that is relevant to AAN interests or activities. Dr. Flanagan has a non-compensated relationship as a Editorial board member with Journal of The Neurologic Sciences that is relevant to AAN interests or activities. Dr. Flanagan has a non-compensated relationship as a Editorial board member with Neuroimmunology Reports that is relevant to AAN interests or activities. Dr. Aksamit has nothing to disclose. Dr. Redenbaugh has nothing to disclose. Dr. Clardy has received personal compensation for serving as an employee of Veterans Health Administration (VHA). Dr. Clardy has received personal compensation for serving as an employee of University of Utah Health. Dr. Clardy has received personal compensation in the range of $0-$499 for serving as a Consultant for Clarion. Dr. Clardy has received personal compensation in the range of $500-$4,999 for serving as a Consultant for ExpertConnect. The institution of Dr. Clardy has received personal compensation in the range of $0-$499 for serving as a Consultant for VielaBio. The institution of Dr. Clardy has received personal compensation in the range of $0-$499 for serving as a Consultant for Genentech. The institution of Dr. Clardy has received personal compensation in the range of $500-$4,999 for serving as a Consultant for Alexion. The institution of Dr. Clardy has received personal compensation in the range of $0-$499 for serving as a Consultant for GuidePoint. Dr. Clardy has received personal compensation in the range of $10,000-$49,999 for serving as an Editor, Associate Editor, or Editorial Advisory Board Member for Neurology/AAN Publications. The institution of Dr. Clardy has received research support from Alexion Pharma. The institution of Dr. Clardy has received research support from Sumaira Foundation for NMO. The institution of Dr. Clardy has received research support from Immune Deficiency Foundation. The institution of Dr. Clardy has received research support from Western Institute for Veteran Research. The institution of Dr. Clardy has received research support from NIH/NINDS. Dr. Clardy has received personal compensation in the range of $500-$4,999 for serving as a AAN Summer Meeting CoDirector Travel and Lodging with AAN. Dr. Clardy has received personal compensation in the range of $500-$4,999 for serving as a Grand Rounds Travel and Lodging with U of Iowa. Dr. Clardy has received personal compensation in the range of $500-$4,999 for serving as a Speaker Honoraria for Grand Rounds with Barrow Neurological Institute. Dr. Samudralwar has received personal compensation in the range of $500-$4,999 for serving on a Scientific Advisory or Data Safety Monitoring board for Sanofi Genzyme. Dr. Samudralwar has received personal compensation in the range of $500-$4,999 for serving on a Speakers Bureau for Biogen. Dr. Samudralwar has received personal compensation in the range of $500-$4,999 for serving on a Speakers Bureau for EMD Serono. Dr. Agyei has nothing to disclose. Dr. Zabeti has received personal compensation in the range of $10,000-$49,999 for serving on a Speakers Bureau for Alexion. Dr. Zabeti has received personal compensation in the range of $5,000-$9,999 for serving on a Speakers Bureau for Alexion. Dr. Zabeti has received personal compensation in the range of $10,000-$49,999 for serving on a Speakers Bureau for Biogen. Dr. Zabeti has received personal compensation in the range of $5,000-$9,999 for serving on a Speakers Bureau for Biogen. Dr. Zabeti has received personal compensation in the range of $10,000-$49,999 for serving on a Speakers Bureau for Genentech. Dr. Zabeti has received personal compensation in the range of $5,000-$9,999 for serving on a Speakers Bureau for Genentech. Dr. Zabeti has received personal compensation in the range of $10,000-$49,999 for serving on a Speakers Bureau for Novartis. Dr. Zabeti has received personal compensation in the range of $5,000-$9,999 for serving on a Speakers Bureau for Novartis. Dr. Zabeti has received personal compensation in the range of $10,000-$49,999 for serving on a Speakers Bureau for Sanofi-Genzyme. Dr. Zabeti has received personal compensation in the range of $5,000-$9,999 for serving on a Speakers Bureau for Sanofi-Genzyme. Dr. Zabeti has received personal compensation in the range of $5,000-$9,999 for serving on a Speakers Bureau for Viela Bio. Dr. Zabeti has received personal compensation in the range of $5,000-$9,999 for serving on a Speakers Bureau for Viela Bio. Dr. Zabeti has received personal compensation in the range of $10,000-$49,999 for serving on a Speakers Bureau for BMS. Dr. Zabeti has received personal compensation in the range of $10,000-$49,999 for serving on a Speakers Bureau for BMS. Robert Baughman, PhD has nothing to disclose. Dr. Chwalisz has nothing to disclose. Dr. Levy has received personal compensation in the range of $500-$4,999 for serving as a Consultant for Mitsubishi Pharma. Dr. Levy has received personal compensation in the range of $500-$4,999 for serving as a Consultant for UCB Pharma. Dr. Levy has received personal compensation in the range of $5,000-$9,999 for serving as a Consultant for Sanofi. Dr. Levy has received personal compensation in the range of $5,000-$9,999 for serving on a Scientific Advisory or Data Safety Monitoring board for Alexion. Dr. Levy has received personal compensation in the range of $5,000-$9,999 for serving on a Scientific

Advisory or Data Safety Monitoring board for Horizon. Dr. Levy has received personal compensation in the range of $5,000-$9,999 for serving on a Scientific Advisory or Data Safety Monitoring board for Genentech. Dr. Levy has received personal compensation in the range of $500-$4,999 for serving as an Editor, Associate Editor, or Editorial Advisory Board Member for Elsevier. Dr. Levy has received personal compensation in the range of $10,000-$49,999 for serving as an Expert Witness for Various law firms. The institution of Dr. Levy has received research support from National Institutes Health. Dr. Bhattacharyya has received personal compensation in the range of $500-$4,999 for serving on a Scientific Advisory or Data Safety Monitoring board for Alexion Pharmaceuticals. The institution of Dr. Bhattacharyya has received research support from Alexion Pharmaceuticals. Dr. Bhattacharyya has received publishing royalties from a publication relating to health care. Dr. Bhattacharyya has received publishing royalties from a publication relating to health care. Dr. Bhattacharyya has received publishing royalties from a publication relating to health care.

Resolution of Recurrent VZV Myelitis With the Use of Intravenous (IV) Immunoglobulin (IG)

Danelvis Paredes, Elijah Lackey, Christopher Eckstein

Objective

To present a case of a patient with recurrent VZV myelitis successfully treated with Intravenous Immunoglobulin (IVIG).

Background

VZV myelitis is a rare complication of VZV reactivation that tends to be monophasic. There is no solid evidence for a particular treatment regimen for VZV myelitis. No prior reports or studies have looked at using intravenous immunoglobulin for this condition, particularly for refractory cases.

Design/Methods

75 year old female with history of hypertension presented with paresthesia on lateral side of right lower extremity, followed by vesicular rash T2 dermatomal distribution. Over a period of 2 weeks patient started experiencing bilateral lower extremity weakness R>L. CNS imaging revealed C3-C6 enhancing lesion and T2 hyperintense lesion. VZV confirmed by skin biopsy. Lumbar puncture (LP) was remarkable only for mildly elevated protein (67 mg/dL), although this LP was 4 weeks after initial symptoms. Patient was treated initially with 5 days of 1 g IV Solumedrol and valacyclovir 1 g TID with improvement of weakness and rash. However, over the next two years, the patient continued to get occasional vesicles with a flare of her myelitis shortly after valacyclovir down-titration trial. She was started on monthly IVIG (1 g/kg IVIG over 2 days) given her refractory and recurrent myelitis. Since starting monthly IVIG, the patient has not had any more zoster outbreaks or further episodes of myelitis. She has gradually improved her balance and gait as well.

Results

N/A.

Conclusions

We present an unusual case of recurrent VZV myelitis successfully treated with monthly IVIG. The successful treatment of this patient with IVIG should prompt consideration for its use in similar cases of recurrent VZV myelitis and may provide insight for future studies on how to treat VZV-related diseases. Rapid initiation of this treatment when the condition is recognized early could significantly improve outcomes and patients' quality of life.

Disclosure: Dr. Paredes has nothing to disclose. Dr. Lackey has nothing to disclose. The institution of Dr. Eckstein has received research support from Biogen. The institution of Dr. Eckstein has received research support from Genzyme.

Sjogren's Sensory Neuropathy: A Potentially Treatable Condition with Early Intervention

Ryan Naum, Kelly Gwathmey

Objective

To describe 2 cases of Sjögren's syndrome sensory neuronopathy (SSSN) in which early intervention resulted in excellent clinical outcomes.

Background

Acquired sensory neuronopathies (i.e. dorsal root ganglionopathies) are rare sensory neuropathies most commonly associated with Sjögren's syndrome (SS) and paraneoplastic syndromes.

Design/Methods

We describe 2 patients who presented with painful sensory symptoms, sicca symptoms and with positive SSA and antinuclear antibodies. The first patient presented with perceived symmetric hand weakness (despite no motor nerve conduction abnormalities), total body numbness and paresthesia, as well as sensory ataxia, while the other presented with asymmetric numbness and pain in the left foot and hand. The electrophysiological profiles varied considerably between the 2 patients. The first patient demonstrated complete absence of sensory nerve action potentials (SNAPs) whereas the second patient had only asymmetrical superficial peroneal and sural SNAPs, corresponding with his clinical deficit. The first patient was diagnosed with SSSN, while the other was diagnosed with asymmetrical sensory neuropathy in SS. The first patient was treated with mycophenolate mofetil (MMF) with dramatic symptomatic improvement and near recovery of clinical deficits. The second patient was treated with prednisone, methotrexate, and ultimately switched to MMF and rituximab with significant improvement in symptoms.

Results

NA.

Conclusions

SS is commonly associated with sensory neuropathies including sensory neuronopathies. Both patients met diagnostic criteria for SSSN, though with differing severities. To date, there has been no randomized controlled trial evaluating treatments of SSSN. However, our findings suggest that early use of MMF could result in considerable benefit in a disease that is often functionally devastating.

Disclosure: Dr. Naum has nothing to disclose. Dr. Gwathmey has received personal compensation in the range of $500-$4,999 for serving as a Consultant for Alexion Pharmaceuticals. Dr. Gwathmey has received personal compensation in the range of $500-$4,999 for serving as a Consultant for Argenx. Dr. Gwathmey has received personal compensation in the range of $500-$4,999 for serving as a Consultant for Argenx. Dr. Gwathmey has received personal compensation in the range of $500-$4,999 for serving as a Consultant for Strongbridge. Dr. Gwathmey has received personal compensation in the range of $500-$4,999 for serving on a Scientific Advisory or Data Safety Monitoring board for Alexion Pharmaceuticals. Dr. Gwathmey has received personal compensation in the range of $500-$4,999 for serving on a Speakers Bureau for Alexion Pharmaceuticals.

NMDA Receptor Encephalitis With Severe Orofacial Dyskinesias Treated With Tramadol and Clonazepam

Falen Fernandes, Fraser Clift, Laura Chu

Objective

N/A.

Background

Anti-N-methyl-D-aspartate receptor (NMDAR) encephalitis is a neuroinflammatory disease mediated by antibodies targeting the GluN1 subunit of the NMDAR. It presents with well-defined neuropsychiatric symptoms, including psychosis, agitation, seizures, and memory disturbances.1 Movement disorders including orofacial dyskinesias are common, but often difficult to manage, with no specific published guidelines.[1,2,3]

Characterization of Neurosarcoid Myelitis and Assessment of Treatment Response: A Multicenter Retrospective Study

Denis Balaban, Giovanna Manzano, Ahya Ali, et al.

Neurology 2022;99;S24-S25
DOI 10.1212/01.wnl.0000903208.61287.7f