

Results: The difference in MoCA (0.029) and RUDAS (0.0041) scores between patients with different levels of educational attainment ($n = 141$) was significant. The difference in MoCA (0.62) and RUDAS (0.78) scores between patients with a different first language ($n = 141$) was not significant. The difference in MoCA (0.64) and RUDAS (0.96) scores between patients of different race ($n = 141$) was not significant. Conclusions: The difference between MoCA and RUDAS scores remained consistent regardless of level of educational attainment, first language and race. The results suggest that the RUDAS may not be more appropriate than the MoCA in detecting MCI and dementia across diverse populations.

EPILEPSY AND EEG

P.10

Adding a neuroimaging safety net to the work up of status epilepticus at the Ottawa Hospital

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Background: CT angiogram of the head and neck (CTA) is not part of the routine work-up of status epilepticus (SE), which could miss acute ischemic stroke (AIS) as the cause. We hypothesized that healthcare savings from early treatment of otherwise undiagnosed AIS would be greater than the cost of adding a routine CTA for work-up of SE (all comers). Methods: The total number of patients presenting to ER with SE (defined as seizure/epilepsy + hospital admission), and the subgroup who were diagnosed with a new ischemic stroke, or received a CTA were retrospectively calculated at the Ottawa Hospital between 2010-2019. CTA costs, and savings of early treatment of AIS were obtained from the Department of Radiology and literature review, respectively. Results: 727 individuals presented with SE. 3% ($n=22$) had a new ischemic stroke-of these, 95% ($n=21$) did not receive a CTA (considered missed AIS). Assuming CTA could help detect every case of ischemic stroke missed this could result in 2.27 additional strokes caught early/year, and assuming if all thrombolysis candidates this would net cost \$7,967/year (vs no acute treatment), or if all thrombolysis+thrombectomy candidates would net save \$19,823/year (vs thrombolysis alone). Conclusions: Routine CTA in SE in the ER has potential to result in healthcare savings.

P.011

Is the effect of the vagus nerve stimulation different in lesional and nonlesional medically resistant epilepsies?

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Background: The incidence of drug resistant epilepsy (DRE) is around 30% patients with epilepsy. Vagus nerve stimulation

(VNS) is offered to patients who are not candidates for epilepsy resective surgery, however the results of lesional cases has not been explored previously Methods: The study was a retrospective cohort study that involved patients with DRE implanted with VNS at the Epilepsy program at Western University, Ontario. We classified our VNS cohort based on brain imaging of lesional (L) and nonlesional (NL) epilepsy. Results: The median age was 31.8 years, 70.69% were females. The VNS-L group average age was 31.8 years and the NL 35.2 years. The most common abnormality was nodular heterotropias 31.34% ($n=9$). 16 patients underwent palliative procedures before the VNS implantation, 12 in VNS-L and 4 in VNS-NL. The median period of follow-up was 69.97 months. 62% of the VNS-L group had a seizure reduction of 50% or greater, compared to 41.38% in the VNS-NL group. Seizure freedom was 10.34% in VNS-L, compared to 6.99% in VNS-NL. Conclusions: This is the first study reporting the outcome of VNS in lesional cases. Our results suggest that VNS in lesional cases is effective. However, a large multicenteric study is needed.

HEADACHE

P.013

Patient preferences for selection of preventive migraine therapies in Canada: results from a discrete choice experiment

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Background: This study assessed the importance of mode of administration relative to other treatment attributes when selecting a preventive migraine therapy. Methods: Cross-sectional study among Canadian adults diagnosed with migraine with ≥ 5 monthly migraine days and tried ≥ 2 prescription migraine treatments (any kind/duration). Preferences for treatments varying in the following attributes were evaluated via a discrete choice experiment: speed of efficacy (effective in 24hr/1wk/3mo), duration of efficacy (wears off never/1wk/2 wks before next dose), mode of administration (infusion/auto-injection/cranial injections), administration setting (clinic/home), and administration frequency (1mo/3mo). Attribute-level preference weights were estimated using Hierarchical Bayes modeling. Results: Of 200 respondents, 142 experienced episodic migraine and 58 experienced chronic migraine. Preference weights confirmed that respondents' most preferred treatments were those that provided fast and long-lasting efficacy (effective in 24hr = 0.59; wears off never = 1.07) and were offered via infusion (0.58) or auto-injection (0.47) over intracranial injection (-1.04). Respondents reported being moderately willing to receive infusions in either a home or clinic setting (1-6 Likert scale from "not at all" to extremely" willing). Conclusions: Second to speed and duration of efficacy, respondents were most concerned with mode of administration when selecting their preferred migraine preventive, suggesting that physicians should consider patient preferences in treatment decision-making.