

Background: International medical exchange programs have multiple benefits to neurology trainees and their home institutions including the provision of humanitarian aid, new learning and teaching opportunities, clinical independence, reputation, and a better-educated global health workforce.

Methods: A survey was electronically distributed to all program directors in the U.S. and Canada by the American Academy of Neurology (Oct. 2012–Feb. 2013) to assess the training opportunities, institutional partnerships, and support available to postgraduate neurology trainees to participate in electives in countries outside of Western Europe, Australia, Canada, and the U.S.

Results: A total of 143/234 (61%) program directors responded. Most (53%) programs allow global health electives; however, just 33% provide financial support and 55% state that less than 10% of trainees actually go abroad. Among programs that do not allow global health electives, 86% cited a lack of funding, 55% stated there were no formal programs or partnerships with international sites, and 31% perceived no interest by residents. Only 12% of programs solicit philanthropic donations. If funding were not an issue, 93% of program directors believed their residents would have time to participate in global health training.

Conclusions: In spite of high perceived interest, only half of U.S. and Canadian neurology training programs currently permit global health electives, and the number of trainees venturing abroad remains a minority of all trainees in all programs.

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Abstract – WCN 2013

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Topic: 36 – Other Topic

Medication use by individuals with motor neuron disease

L.W. Svenson^{a,b,c}, R.L. Campbell^d, D.P. Schopflocher^{a,e}. ^aSchool of Public Health, University of Alberta, Edmonton, Canada; ^bCommunity Health Sciences, University of Calgary, Calgary, Canada; ^cSurveillance and Assessment, Alberta Health, Edmonton, AB, Canada; ^dConcordia University College of Alberta, Edmonton, AB, Canada; ^eFaculty of Nursing, University of Alberta, Edmonton, AB, Canada

Background: Motor neuron disease (MND) is a chronic condition of unknown etiology characterized by a progressive degeneration of motor neurons leading to weakness, skeletal muscle wasting, and respiratory failure.

Objective: The objective of this study was to quantify to the use of prescription medications by MND patients.

Methods: The Province of Alberta maintains a publicly funded, universally available health care system. A number of administrative databases are maintained and include all physician visits and virtually (>95%) all prescriptions dispensed. A case was defined as individuals receiving three or more services, within a 12 month period, with an ICD-9 code of 335.2. Prescription drugs dispensed were extracted for MND cases for the period January 1 to December 31, 2011. Drugs were grouped using the Anatomical Therapeutic Chemical (ATC) coding system.

Results: 426 MND cases (147 females; 269 males) were included in the study and 39.4% died in 2011. The mean age was 62.2 years (std = 14.6), while the mean duration of illness was 3.7 years (range: < 1 to 18.5 years) with no difference between the sexes for either. Within 2011, the median number of prescriptions filled was 20, and the median number of medication classes was 7. 13% of patients were using Riluzole. The most common drug classes used were analgesics, psycholeptics, psychoanaleptics, antiepileptics, angiotensin inhibitors, and ulcer therapeutics.

Conclusion: Individuals with MND are prescribed a larger number of medications. An understanding of medication use can help

to guide practice to reduce the risk of unintended medication interactions.

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Maybe all is not so Rose in cephalic tetanus

Z. Kone^a, Y. Maiga^b, C.O. Guinto^a. ^aNeurology, Point G Teaching Hospital, University of Bamako, Bamako, Mali; ^bNeurology, Gabriel Toure Teaching Hospital, University of Bamako, Bamako, Mali

Introduction: Cephalic tetanus is a rare localized form of tetanus with facial palsy the most of the time follows a wound to the face.

Observation: We report the case of a patient with facial palsy but with wound in the foot.

Discussion: The diagnosis of this localization of tetanus is based on some clinical criteria like trismus and a entrance door in face.

But what will happen if you have a patient who is not vaccinated with foot's wound then facial palsy?

Conclusion: Needs new guidelines revised in light of new knowledges in the field of neuroscience for tropical neurological diseases.

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Toxoplasma encephalitis in an immunocompetent diabetic patient

N. Oztekin^a, F. Oztekin^b. ^aNeurology, MOH Ankara Numune Education and Research Hospital, Ankara, Turkey; ^bNeurology, MOH Ankara Yıldırım Beyazıt Education and Research Hospital, Ankara, Turkey

Background: Toxoplasmosis may have severe consequences in immunocompromised patients but cerebral toxoplasmosis is very rare in immunocompetent patients. Herein we present a case of toxoplasma encephalitis in an immunocompetent diabetic patient.

Case: A 54 year old female was admitted with abrupt onset visual loss, weakness evolving to quadriplegia in two weeks, lethargy and high fever. She was diabetic. Neurologic examination revealed a stuporous patient with poor cooperation. Fundi were bilateral hemorrhagic. In cranial MRI DWI revealed diffusion restriction in the anterior part of the right lateral ventricle. Her antitoxo Ig G and Ig M antibodies were positive. A second MRI revealed hyperintense lesions in periventricular frontal areas, posterior part of the left cerebral hemisphere and corpus callosum. An ependymal lesion was seen in right lateral ventricle. Hyperintense lesions were observed in FLAIR sequences consistent with hemorrhage in posterior parts of the lateral ventricles as well as linear hyperintensities in the sulci. The second CT showed hemorrhage in the posterior horns of the lateral ventricles. CSF pressure was high and CSF was hemorrhagic. She was considered as toxoplasma encephalitis and immediate treatment was started, but the patient was unresponsive to treatment and died at the 6th hospital day.

Conclusion: Toxoplasma encephalitis is a very rare condition and the absence of classical abscess formation in MRI in immune competent patients makes the diagnosis very difficult. Toxoplasmosis encephalitis must be kept in mind in the differential diagnosis diabetic patients with encephalitic signs and symptoms.

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