Poster Tour: Vascular

May 7, 12:30 - 13:30

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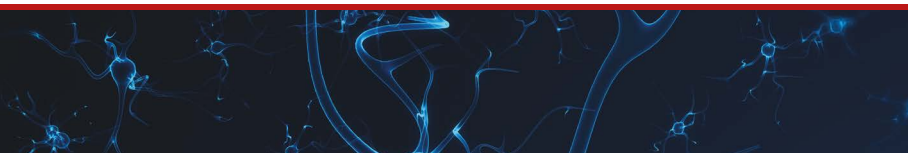

A case of Moyamoya syndrome associated with Grave's disease

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A 36-year-old female with a background of Grave's disease presented to the TIA clinic with three discrete 10 minutes episodes of dysarthria, weakness and hypoaesthesia affecting the left face and arm, accompanied by a generalised holocephalic headache over 72 hours.

In the clinic review, she had no focal neurological deficit. A palpable, non-tender goitre was noted. She was clammy and had a fine tremor with her hands outstretched. She was non-compliant with her Carbimazole over the preceding 6 months.

Initial blood work-up revealed florid thyrotoxicosis. CT Head was unremarkable with no evidence of established infarction. A CT angiogram of the aortic arch, carotids and intra-cranial vasculature demonstrated severe stenosis of the terminal right ICA similar, less marked changes on the left side, along with bilateral M2 branch occlusions.

Vasculitis was raised as a differential diagnosis and thus, she went on to have a lumbar puncture which was unremarkable. Her systemic vasculitic panel was negative.

MRI and MRA head demonstrated intracranial atheromatous disease as the primary cause of the arterial stenosis, with features atypical for CNS vasculitis.

A diagnosis of moya-moya syndrome in the context of Grave's disease was formulated.

Moyamoya syndrome can occur as a rare complication of Graves' disease.

Challenging case of Bilateral Opercular syndrome

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Introduction: Foix–Chavany–Marie syndrome (FCMS) is a rare form of supra-bulbar palsy resulting from bilateral lesions of the anterior operculum. It is characterized by the "automatic-voluntary dissociation" of the facio-pharyngo-glosso-masticatory muscles.

This report describes a diagnostic challenge where FCMS emerged from two distinct vascular events occurring a decade apart.

Case Presentation: A 68-year-old woman with a history of hypertension, diabetes and a left total anterior circulation infarct 10 years prior, presented with acute, profound dysarthria and dysphagia.

Neurological examination revealed residual right-sided weakness and anarthria. While the acute presentation initially suggested a brainstem event, magnetic resonance imaging (MRI) revealed an acute infarct in the right corona radiata. Comparison with historical imaging confirmed a previous left insular infarct. The combination of these sequential, bilateral opercular-subcortical lesions confirmed the diagnosis of FCMS.

Management and Outcome: Due to severe dysphagia and the high risk of aspiration, the patient required a percutaneous endoscopic gastrostomy (PEG) for nutritional support. She also required intensive speech and language therapy to address anarthria.

Conclusion: This case highlights that FCMS can present asynchronously, with the second "trigger" stroke occurring years after the first. Awareness of the condition, Early recognition, and multidisciplinary management are essential to optimize patient outcomes.

Enhancing Secondary Stroke Prevention: An Audit at Derriford Hospital, Plymouth

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Torbay and South Devon NHS Foundation Trust

Background: Stroke is a leading cause of death and disability worldwide. In the UK, stroke costs £3 billion annually, plus £4 billion in lost productivity and disability care. Effective secondary prevention is essential to reducing recurrence and improving outcomes.

Objectives: This audit evaluated adherence to national secondary stroke prevention guidelines at Derriford Hospital, focusing on antithrombotic use, lipid management, angiographic assessments and Holter monitoring. Secondary objectives included lipid monitoring, treatment adjustments, and antiplatelet selection in recurrent stroke cases.

Methods: A retrospective audit was conducted on 100 ischemic stroke patients seen at Derriford Hospital (November 2023–February 2024). Clinical letters, discharge summaries, and electronic records were reviewed.

Results: Antiplatelet and lipid-lowering therapy were prescribed in all cases as per guidelines, though documentation was missing in 3 cases. Clopidogrel was the most used antithrombotic (54%). Atorvastatin was prescribed in 92% of cases, however, follow-up lipid monitoring and dose adjustments were recorded only in 50%. Angiographic assessments and Holter monitoring were performed in most patients.

Conclusion: While prescribing was guideline-compliant, gaps in follow-up monitoring, treatment adjustments, and diagnostic assessments were identified. Improved communication with primary care, standardized discharge instructions

A rare (but treatable) cause of both ischaemic and haemorrhagic stroke in a young adult

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Case Presentation: A 40-year-old gentleman presented with an acute left sided headache followed by bilateral lower limb weakness and numbness. Examination found dense left leg weakness. CT head showed a 5mm acute right precentral gyrus haemorrhage. MRI head with contrast showed multi-focal acute infarcts within both cerebral hemispheres, with haemorrhagic transformation of the right precentral gyrus infarct. His left leg became cold and pulseless. CT angiogram of aorta and lower limbs showed a large thrombus in the left atrium with distal embolisation leading to bilateral critical limb ischaemia requiring urgent vascular intervention. Echo-cardiogram revealed a 4.9x2.9cm mobile echogenic mass within left atrium suspicious for myxoma which was surgically resected. He re-presented twice six months later with left-sided sensory disturbances. CT imaging showed recurrence of the right central sulcus haemorrhage on both occasions. MRI was suggestive of myxomatous metastasis, treated with stereotactic radiosurgery. He currently lives independently and remains under surveillance.

Discussion: Cardiac myxomas are the most common primary cardiac tumours in adults. Originating from multipotent mes-enchymal cells, these benign neoplasms can cause a variety of clinical manifestations including embolic stroke. They have an excellent prognosis when resected. Complications of myxoma-embolisation include myxomatous metastasis and cerebral aneurysm, both with bleeding risks.

Multiple simultaneous acute infarcts as a presentation of CADASIL, and its association with recent infection

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Background: Cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy(CADASIL) is the commonest monogenic cause of stroke and usually presents with single lacunar infarct. However multiple simultaneous infarcts have been reported, particularly following the COVID-19 pandemic.

Methods: We retrospectively reviewed a prospectively recruited CADASIL registry from a British National Referral Clinic to identify cases with multiple simultaneous acute infarcts. We combined this with data from a systematic review on MEDLINE, Embase, Web of Science, and Cochrane Library from inception to 17/06/2025. Multiple simultaneous infarcts were defined as multiple diffusion-restricted lesions on brain MRI.

Results: Eight cases (5 male) with mean age 49.6±13.1 were identified from 613 CADASIL cases, yielding an estimated point prevalence of 1.3%. All had a recent infection(SARS-CoV-2 3, unspecified infections 4, and Campylobacter 1). The systematic review identified 34 cases from 27 studies, comprising 42 cases in total. Mean age was 46.2±10.5 years, and 24 were male. Triggering events were identified in 30, with infections being the most common(N=24), followed by post-surgical procedure(N=4), trauma(N=1) and anaemia(N=1). 39 cases had bilateral internal watershed infarcts.

Conclusions: Multiple simultaneous infarcts are a rare but important manifestation of CADASIL, typically presenting with bilateral watershed lesions and frequently triggered by infection.

What are we missing? A decade of auditory symptoms in the TIA clinic

Sashini Mariathasan[1], Rashad Alijam[1], Clara Tierney[1], Teona Serafimova[1], Ahmed Hammam[2], Arvind Chandratheva[1], Nehzat Koohi[3], Diego Kaski[4], Mohammad Mahmud[4]

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Background: Sudden-onset sensorineural hearing loss and pulsatile tinnitus are commonly managed via ENT and emergency pathways that prioritise urgent corticosteroids for presumed idiopathic inner-ear inflammation, with limited stroke-facing guidance. We quantified auditory presentations to a tertiary TIA service and subsequent neurovascular diagnoses.

Methods: Prospectively collated consecutive referrals to UCLH TIA service between June 2015 and November 2025 were analysed. Referral reasons were categorised into neurological symptom clusters. "Auditory symptoms" encompassed hearing loss and tinnitus. We calculated the proportion of referrals with auditory symptoms as the reason for referral and subsequent outcomes.

Results: Of 14,749 new referrals, 49 (<0.5%) were for auditory symptoms. Out of 46 patients who attended clinic, 5/46 were diagnosed with definite or probable stroke/TIA and 2/46 with cervical artery dissection. One dissection presented with isolated sudden-onset pulsatile tinnitus and headache without other neurological features.

Conclusion: Although infrequently captured as the front-door phenotype, sudden hearing loss/pulsatile tinnitus can signal serious neurovascular disease and should prompt timely neurovascular imaging in selected cases.

For this to be achieved, there may be a need for collaborative pathway development for referrals initially made to ENT rather than stroke services, given low rates of referrals to TIA services for auditory symptoms.

A Decade of Vestibular Presentations to TIA Service: A High-Risk Cerebrovascular Presentation

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Aims: Vestibular symptoms are common in emergency settings but are often perceived as low risk for cerebrovascular disease. We aimed to quantify the burden of vestibular presentations to a large tertiary transient ischaemic attack (TIA) service and determine associated stroke and TIA diagnoses.

Methods: Prospectively collated consecutive referrals to a central London TIA service between June 2015 and November 2025 were analysed. Patients with missing data were excluded from further analysis. Referral reasons were categorised into neurological symptom clusters. Vestibular presentations were defined using Bárány Society-informed descriptors, including vertigo, dizziness, imbalance, unsteadiness, and giddiness. We calculated the proportion of vestibular referrals and subsequent stroke/TIA diagnoses, comparing outcomes using logistic regression.

Results: Vestibular symptoms accounted for 14% (n=1,783) of 12760 new referrals. Patients referred with isolated vestibular symptoms had a definite or probable stroke/ TIA diagnosis rate of 24% (n=241/994), which significantly increased to 39% (n=306/789) for those referred with vestibular symptoms in addition to other neurological symptoms (OR 1.98, 95% CI 1.62–2.43; p<0.001).

Conclusion: Vestibular presentations to a specialist TIA clinic carry a substantially higher cerebrovascular diagnostic rate than estimates from ED-based cohorts. Findings support low thresholds for specialist assessment to reduce missed posterior circulation events.

The Stroke Unit as a Portal for Primary Prevention: Screening At-Risk Relatives

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Introduction: Hypertension is the primary modifiable driver of the UK stroke burden. Relatives of stroke patients share genetic and lifestyle risks and possess heightened awareness of personal risk following a family member's admission. We evaluated the feasibility of a hospital-based screening programme for this high-yield cohort.

Methods: This prospective pilot study (Darent Valley Hospital, 2025) screened relatives of patients on Hyper-Acute and Acute Stroke Units. Participants underwent blood pressure (BP) measurement and completed a questionnaire. Those with elevated readings (≥140/90mmHg) received lifestyle advice and GP follow-up recommendations.

Results: 41 participants were screened. 29% (n=12) had pre-existing hypertension, of whom 42% (n=5) were sub-optimally controlled. 14% (n=6) of the total cohort had newly detected hypertension. Overall, 27% (n=11) required intervention, with 91% (n=10) consenting to telephone follow-up.

Conclusion: By leveraging the unique motivation of at-risk relatives, hospital-based screening is feasible and effective at identifying hypertension, bridging the gap between secondary care and primary prevention. Our findings highlight the need for a national strategy that integrates family-based screening into standard post-stroke care, potentially leading to more targeted, cost-effective, and impactful public health interventions on a larger scale.

Immune effector cell-associated neurotoxicity syndrome (ICANS) with intracerebral haemorrhage – a case report

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Intracerebral haemorrhage (ICH) and Immune effector cell–associated neurotoxicity syndrome (ICANS) are rare, but potentially fatal neurological complications following chimeric antigen receptor T-cell (CAR-T) therapy. However, early identification of high-risk patients could improve outcomes.

We report a case of a 69-year-old man, with mantle cell lymphoma, diagnosed in September 2014 and relapsed in November 2024, treated with CAR-T therapy, post infusion, developed acute neurocognitive deterioration, consistent with ICANS. Following development of seizures, 5 months after CAR-T therapy, neuroimaging demonstrated cerebral microhaemorrhages, on CT and MRI brain. Laboratory results showed thrombocytopenia and coagulopathy, consistent with cytokine release syndrome. These findings supported ICANS diagnosis, complicated by intracerebral haemorrhage.

He initially demonstrated a persistent disorder of consciousness in ITU, neurological and haematological advice was sought regarding withdrawal of care, however continuation of supportive treatment was advocated. Gradual recovery occurred, over months and he was subsequently discharged to undergo neurological rehabilitation have regained consciousness and voluntary movement with ability to perform some basic functional tasks by August 2025.

This case highlights survival and meaningful, though slow, recovery in a severe case of ICANS, following CAR-T therapy. Early recognition of risk factors, prompt neuroimaging, and multidisciplinary management could reduce neurological morbidity.

Striking clinico-radiological dissociation in hypertensive brainstem encephalopathy complicated by delayed brainstem haemorrhage

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Background: Hypertensive brainstem encephalopathy (HBE) is a rare variant of posterior reversible encephalopathy syndrome, characterised by severe systemic hypertension, vasogenic oedema isolated to the brainstem and clinico-radiological dissociation. Haemorrhagic complications are uncommon and typically seen in the acute phase.

Case: A 37-year-old female with hypertension and type 2 diabetes mellitus was referred after bilateral optic disc oedema was identified on routine screening. Brain MRI demonstrated extensive T2 hyperintensity of the pons with extension to the midbrain and medulla with no significant supratentorial involvement. Despite these findings, the only reported symptom was intermittent mild headache, and neurological examination was unremarkable. Blood pressure was found to be severely elevated at 239/155 mmHg.

She was diagnosed with HBE and treated with antihypertensives. Repeat MRI at three months showed near-complete resolution. Seventeen months later, she re-presented with hemisensory symptoms and diplopia, and imaging demonstrated a brainstem haemorrhage.

Discussion: The incidental presentation in this case highlights the profound clinico-radiological dissociation that can be seen in HBE. Recognition of this enables timely management and avoids unnecessary invasive investigations. Delayed brainstem haemorrhage following radiological resolution suggests prolonged vascular vulnerability and underscores the importance of sustained blood pressure control.