

by CGRP blockade such as menopause symptoms, insulin resistance. Also, it seems that gonadal hormones type and levels likely have a role in determining proneness to several pro and cons in middle aged males and females M sufferers

Disclosure of Interest: None Declared

IHC23-PO-145

Features of headache in patients with chronic kidney disease

Sevara Khudayarova and Gulnara Rakhmatullaeva

Tashkent Medical Academy, Tashkent, Uzbekistan

Relevance: Headache in patients with chronic kidney disease is one of the most frequent clinical manifestations of this condition.

The aim of the study: To study the frequency and intensity of headache depending on gender characteristics in patients with CKD

Materials and methods of the study: 101 patients with CKD were examined.

Of these, 66 (65.3%) are men, and 35 (34.3%) are women. The average age of all patients was 46.2 ± 15.01 years, while the average age of men was 42.2 ± 12 years, the average age of women was 39.3 ± 11.5 years. In the predialysis stage C1-C4 ($n=28$), 15 males (53.5%) and 13 females (46.6%) prevailed, while the average age in this group of patients was 56.1 ± 12.1 . In the group of patients who receive hemodialysis ($n=30$), gender gradation also showed a clear bias in favor of the stronger sex 18 (60%):12(40%); the average age was 53.1 ± 13.3 . In group 3 ($n=43$) there were similar data of men 23(53,4%); 20 (46,5%) women, average age 34.8 ± 9.3 .

Results of the study: In the group of patients at the predialysis stage of CKD, 24 (85.7%) patients complained of headaches, and 13 (54.1%) of them were women and 13 (45.8%) men. The intensity of headache on the VAS in this group in women was 8 ± 2.1 ($P < 0.05$), in men 5.5 ± 1.7 ($P < 0.05$). In the group of patients undergoing hemodialysis, 22 (73.3%) complained of headaches. Of these, 12 (54.5%) were women, 10 (45.4%) were men. The assessment of pain on the VAS scale in women is 7 ± 1.8 ($P < 0.05$), in men 4.7 ± 2.6 ($P < 0.05$). In the group of patients after transplantation, headache was also one of the most frequent complaints of patients. At this stage, headache was detected in 30 (58.1%). Of these, 20 (66.6%) were women, 10 (33.3%) were men. Assessment of pain on the VAS scale in women is 5 ± 1.8 ($P < 0.05$), in men 3.8 ± 2.6 ($P < 0.05$)

Conclusions: According to the results of the study, CKD of various stages by gender characteristics is more

common in men, but headache among them worries women more often. Also, in patients with kidney pathology, the threshold of sensitivity to headache is higher in women compared to men $7 \pm 2.3:4.7 \pm 1.8$ ($P < 0.05$).

IHC23-PO-146

Prevalence and sex differences in non-headache symptoms and their association with headache characteristics in episodic migraine patients: a cross-sectional study

Samiran Chowdhury and Naresh Rajpal

VPIMS, Lucknow, India

To calculate female-to-male odds ratios for each non-headache symptom, a logistic regression with MMD as covariate was performed. A linear regression model was used to compare the total number of NHS between females and males, MMD as a covariate. The association between each NHS and the namely, monthly headache frequency [low: (2 to 8) versus high (9 to 14)], attack duration without treatment (<8 hours versus ≥ 8 hours) and attack severity assessed by visual analog scale (VAS) (<5 versus ≥ 5) were analyzed by a logistic regression model. *p*-values were adjusted for multiple testing with a Bonferroni correction. To find the relationship between total number of NHS and HIT 6 score, Pearson's correlation was done. The level of significance was set at <0.05

Objectives: To study non-headache symptoms (NHS) in episodic migraine (EM) patients stratified by sex and to find their association with various headache characteristics and headache related disability.

Methods: Consecutive patients with EM diagnosed by ICHD-3 criteria, aged 18 to 65 years seen in the outpatient department, were evaluated regarding the headache and NHS during the past one month using a questionnaire. Demographic details, family history, triggers, disease duration, headache characteristics, and attack-associated non-headache symptoms were recorded. Mean monthly migraine days (MMD), mean attack duration (MAD) and mean attack severity by VAS were estimated. The occurrence of twelve attack-related NHS such as visual aura, photophobia, phonophobia, osmophobia, nausea, vomiting, allodynia, motion sensitivity, neck pain, vertiginous sensation, mental slowing, and myofascial pain/myalgias in any of their attacks were documented. Patients were asked to specify their most bothersome symptom (MBS) amongst NHS. Three leading questions regarding disability were asked (are these non-headache symptoms equally disabling as headache itself? Are they more disabling than headache in some of the attacks? if yes, in what proportions of attacks?). Headache impact was quantified by Headache impact test 6. (HIT-6).

an estimated 9% of patients. Longer symptom-duration is associated with a greater prevalence of brain sagging, whereas the opposite is true for extradural spinal collection.

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IHC23-PO-324

Characteristics of headache, with various encephalopathies developed against the background of chronic kidney disease

Sevara Khudayarova and Gulnora Rakhmatullaeva

Tashkent Medical Academy, Tashkent, Uzbekistan

Relevance: Headache in patients with chronic kidney disease is one of the most frequent clinical manifestations.

The purpose of the study: To study the frequency and characteristics of headache of various types of encephalopathy in patients with CKD

Materials and Methods: 75 patients with CKD were studied. Patients were diagnosed with the following: hypertensive encephalopathy ($n = 33$), uremic encephalopathy ($n = 31$), acute hypertensive encephalopathy (PRES) syndrome ($n = 10$).

Results of the study: In patients with hypertensive encephalopathy ($n = 33$), 31 (93.3%) patients complained of headaches. The GB score on the VAS scale was 7 ± 1.2 ($P < 0.05$). Of these, 25 (75.7%) patients associated headaches with hypertension, and noted a decrease in headaches with a decrease in blood pressure. The pains were paroxysmal, compressive, pulsating, localized mainly in the occipital 15 (60%) and parietal-occipital regions (10 (40%). With uremic encephalopathy ($n = 31$), all 100% complained of headache. The intensity of GB on the VAS scale was 5 ± 2.3 ($P < 0.05$). However, here the headaches were of the nature of aching, persistent pain of a chronic nature, patients noted a decrease in the intensity of pain after the hemodialysis procedure. The pain was diffuse and localized mainly in the frontotemporal 14 (45.1%) and parietotemporal areas. In patients with acute hypertensive encephalopathy ($n = 10$), headache was also one of the first clinical manifestations. However, the pain here was acute, burning in nature, patients describe the pain as an electric shock, lightning. The score on the VAS scale was 9.6 ± 3.2 . Headaches were accompanied by visual impairment in the form of decreased visual acuity 4 (40%), a feeling of shroud 6 (60%) and flickering flies in front of the eyes 6 (60%), nausea 10 (100%) and vomiting 4 (40%).

Conclusions: Headache in patients with CKD is one of the most frequent clinical manifestations, which have different characteristics and localization, as well as intensity depending on the type of encephalopathy.

IHC23-PO-325

Isolated Non-traumatic Convexity Subarachnoid Haemorrhage; Report of a Challenging Diagnosis

Devasmitha Wijesundara and Bimsara Senanayake

Institute of Neurology, National Hospital of Sri Lanka, Colombo, Sri Lanka

Introduction: Subarachnoid haemorrhage (SAH) most commonly occurs due to aneurysmal rupture, where blood is found around the circle of Willis or Sylvian fissure. Rarely, bleeding may be limited to the convexities of the brain. We report a case of convexity SAH presenting as recurrent thunderclap headaches with normal angiography.

Case report: A 53-year-old female presented with three episodes of thunderclap headache over a five-day period. This was accompanied by vomiting and vertigo. She denied ever having an episodic headache disorder. Her history was significant for ischemic heart disease for which she had undergone coronary stenting and was on aspirin. No vasoconstrictive triggers were identified. Her blood pressure was 130/80 mmHg, with a normal general examination. There was no neck stiffness, papilledema, nor any focal neurological deficits. Basic blood investigations, inflammatory markers and coagulopathy screen were normal. Non-contrast computerized tomography (CT) brain revealed hyper-density within the sulci of the left temporo-occipital lobe suggestive of SAH (figure 1A). This was confirmed by magnetic resonance imaging (MRI) (figure 1B-D). There were no other abnormalities. She was started on oral nimodipine and kept under observation. Vascular imaging in the forms of CT angiography, MR angiography, and digital subtraction angiography (DSA) as well as MR venography were all normal (figure 2). Aspirin was restarted on day 5 and she was discharged on day 12, following an uneventful hospital stay. DSA performed after 2 weeks was also unremarkable. The patient remains under close follow up.

Discussion: Convexity SAH is an uncommon entity which occurs secondary to venous thrombosis, amyloid angiopathy, vasculitis, arteriovenous malformations/fistulae, or internal carotid artery stenosis. Reversible cerebral vasoconstriction syndrome (RCVS) and posterior reversible encephalopathy syndrome (PRES) also give rise to this condition. Although, her history was suggestive of RCVS, with a RCVS2 score of 7, this could not be radiologically confirmed. We conclude this to be a rare case of "angio-negative" convexity SAH.

Conclusion: Subarachnoid haemorrhage may rarely manifest as isolated bleeding into sulci. Although it has a good prognosis, etiology should always be sought.