Background
The efficacy and safety of ocrelizumab in relapsing multiple sclerosis were demonstrated in the double-blind control period of the Phase III OPERA I/II trials (NCT01247324/NCT01412333). Results for the 3-year follow-up of the pooled OPERA open-label extension (OLE) period have previously been reported (Hauser SL, et al. ECTRIMS 2018;Abstract P590).

Objective
To assess the efficacy of switching to or earlier initiation of ocrelizumab therapy on disease progression after 4 years' follow-up in the OLE period of OPERA I/II.

Methods
At OLE commencement, patients continued ocrelizumab (OCR-OCR) or switched from interferon (IFN) β-1a to OCR (IFN-OCR). Adjusted annualised relapse rate (ARR) and time to onset of 24-week confirmed disability progression (CDP24) were analysed.

Results
Among IFN-OCR patients, ARR decreased from 0.20 in the year pre-switch to 0.10, 0.08, 0.07 and 0.04 at Years 1, 2, 3 and 4 post-switch. OCR-OCR continuers maintained low ARRs through the year pre-OLE and the 4 years of OLE (0.13, 0.10, 0.08, 0.07 and 0.05). CDP24 was less frequent in OCR-OCR continuers versus IFN-OCR switchers in the year pre-switch and OLE Years 1, 2, 3 and 4 (7.7%/12.0%, 10.1%/15.6%, 13.9%/18.1%, 16.2%/21.3%, 19.2%/23.7%; p<0.05, all comparisons). The safety profile observed in the OLE was generally consistent with the double-blind period.

Conclusions
Switching from IFN to ocrelizumab at the start of the OLE provided rapid reductions in ARR, maintained throughout the 4-year follow-up. After 6 years' follow-up, patients who initiated ocrelizumab 2 years earlier accrued significant, sustained reductions in disability progression compared with patients switching from IFN.

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Poster Session 3
Paroxysmal neurological phenomena in patients with familial amyloidotic polyneuropathy - Is there a need to broaden the classification?
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In patients with familial amyloid polyneuropathy there is accumulation of transtirretin (TTR) in heart and nerve, but in the post-hepatic transplantation era, the TTR produced by the choroid plexus plays an increasingly important in the etiology of the symptoms of this patients. They ere described has presenting short transitory neurological events, including migraine, seizures like episodes, TIAs and “amyloid spells”. According to the one of the largest series most of them seem to occur on average 14.6 years after disease onset and have usually minutes to hours of duration.

A 42 years-old male patient diagnosed with PAF, submitted to liver transplantation presented with a motor aphasia and right hemiparesis. Brain CT was normal. In the day after developed a generalized tonic clonic seizure without recovery of the previous level of consciousness. EEG revealed continuous focal epileptiform activity. The diagnosis of status epilepticus was made and patient started on antiepileptic drug (AED) and 2 days after was seizure free and latter on discharged asymptomatic on AEDs. Tranitory neurologic events are being increasing described in PAF patients, and some of these episodes don’t have a clear etiology although TTR deposits seems do be the main precipitant factor; in some cases there is EEG dysfunction and in others epileptiform activity. In this case, there where clinic an electrographic criterium for status epileticus, which is why one more possible diagnosis to add patients with FAP and

Methods
We describe a 42-year-old female Italian PD patient with a 2-year history of PD, who presented a few month after the onset (October 2017) with III class obesity (BMI 47 kg/m2). To assess the effects of body weight loss both on efficacy of pharmacological treatment and on PD symptoms, the GLP-1 analog Liraglutide was prescribed for obesity (according to Italian guidelines) in adjunct to pramipexole PR 1 mg/day and levodopa/benserazide 400mg/day. Plasma Levodopa levels were investigated.

Results
The overall body weight loss of 29 kg (-21%, from 138 kg to 129 kg) was associated to a significant improvement in the motor disability was paralleled by a 2-fold increase in the area-under-the-curve (AUC from 119 to 235 (ug/ml)*min and the Cmax (from 1.45 to 2.98 ug/ml).

Conclusions
The use GLP-1 analog Liraglutide is able to improve PD motor disability in the short-term, likely because of optimized levodopa pharmacokinetics. It remains to be elucidated whether this is a consequence of either body weight loss or greater levodopa intestinal absorption or both.

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Poster Session 3
Effects of liraglutide in the treatment of severe obesity in a young patient with parkinson’s disease
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Purpose
The Glucagon-like peptide-1 (GLP-1) analog exert disease-modifying effects in patients with Parkinson’s disease (PD). Nonetheless, the significant improvement in motor performance was paralleled by significant reduction in body weight in exenatide-treated PD, so that it could argued that levodopa pharmacokinetics could have been improved by either body weight loss or by other GLP-1-related.

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