international prospective cohort study. We compared workflow times, reperfusion therapy choices, and 90-day modified Rankin scale (mRS) scores. Results: We included 575 patients, mean age 70.2 years (SD: 13.1) and 48.5% female. There were no significant sex differences in onset-to-CT (males: 115 minutes [IQR: 72-171], females: 114 minutes [IQR: 75-196]) or CT-to-thrombolysis time (males: 24 minutes [IQR: 17-32], females: 23 minutes [IQR: 18-36]). However, female participants had a 12-minute faster CT-to-groin-puncture time, p=0.001. Reperfusion therapies did not significantly differ by sex. Reperfusion therapies included thrombolysis alone (males: 46%, females: 49%), EVT alone (males: 34%, females: 34%), thrombolysis plus EVT (males: 8%, females 9%) and conservative management (males: 12%, females: 8%). Median 90-day mRS was 2 (IQR: 1-4) in both males and females, p=0.1. Conclusions: In the INTERRSeCT cohort, rates of reperfusion therapy, workflow times and 90-day outcomes were similar between sexes, suggesting that women are not subject to any poorer performance in key quality indicators for reperfusion treatment for acute stroke.

B.4

Quantitative electroencephalography to predict post-stroke disability: a systematic review and meta-analysis

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Background: We aim to assess the role of quantitative electroencephalography (QEEG) derived indices to predict post-stroke disability. Methods: We included observational studies (sample-size≥10) of patients with stroke who underwent EEG and a follow-up outcome assessment was available either in form of a modified Rankin scale (mRS) or National Institute of stroke scale (NIHSS) or Fugl-Meyer scale (FMA). QEEG indices analyzed were delta-alpha ratio (DAR), delta-theta-alpha-beta ratio (DTABR), brain symmetry (BSI) and pairwise derived brain symmetry (pdBSI). Results: Twelve studies (11 had only ischemic stroke, and one had both ischemic and hemorrhagic stroke), including 513 participants were included for meta-analysis. Higher DAR was associated with worse mRS (n=300, Pearson's r 0.26, 95% CI 0.21-0.31). Higher DTABR was associated with worse mRS (n=337, r 0.32, 95% CI 0.26-0.39). Higher DAR was associated with higher NIHSS (n=161, r 0.42, 95% CI0.24-0.6). Higher DTABR was associated with higher NIHSS (n=172, r 0.49, 95% CI 0.31-0.67). pdBSI was inversely associated with FMA (n=20, r-0.50 95% CI -0.86-(-0.14)) and BSI was not associated with FMA (n=21, r -0.3 95% CI -0.81-0.22). Conclusions: QEEG-derived indices have the potential to assess post-stroke disability. Adding QEEG to the clinical and imaging biomarkers may help in better prediction of post-stroke recovery.

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Child Neurology (CACN)

C.1

The molecular diagnostic landscape of children with seizure onset in the first three years of life

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Background: To clarify the landscape of molecular diagnoses (MDs) in early-onset epilepsy individuals, we determined the prevalent MDs stratified by age at seizure onset (SO) and the time to MD in children with SO <36 months of life. Methods: A panel of up to 302 genes associated with epilepsy was utilized and ordering physicians provided the age of SO. Diagnostic yield analyses were performed for SO ages including <1 mo, 1-2 mo, 3-5 mo, 6-11 mo, 12-23 mo, and 24-35 mo. The time to MD (MD age - SO age) was determined for the top 10 genes in each SO category. Results: 15,074 individuals with SO <36 months of life were tested. Predominant MD findings are as follows: KCNQ2 in neonates with SO at <1mo, KCNQ2 and CDKL5 for SO between 1-2 mo, PRRT2 and SCN1A for SO between 3-11 mo, and SCN1A for SO between 12-36 months. The median time to MD varied by gene. For example, there was no delay in the median time to MD for the GLDC, KCNQ2, and SCN2A genes while the median delay for MECP2, SLC2A1, and other genes was ≥ 12 months. Conclusions: These data highlight the importance of comprehensive early testing in children with early-onset epilepsy.

C.2

SUNFISH parts 1 and 2: 4-year efficacy and safety data of risdiplam in types 2 and 3 spinal muscular atrophy (SMA)

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Background: SMA affects individuals with a broad age range and spectrum of disease severity. Risdiplam (EVRYSDI®) is a centrally and peripherally distributed, oral SMN2 pre-mRNA splicing modifier. Methods: SUNFISH is a multicenter, two-part, randomized, placebo-controlled, double-blind study in patients with Types 2/3 SMA. Part 1 assessed the safety, tolerability and