characteristics, analgesic use, and patient-reported outcomes were collected at baseline and 12-month follow-up. The primary outcome was the composite of reduced average pain intensity and pain interference. Secondary outcomes included assessments of function, mood, and quality-of-life. **Results:** At 12-month follow-up, 13.5% (95%CI,5.6-25.8) of patients achieved ≥30% reduction in pain, whereas 38.5% (95%CI,25.3-53.0) achieved a ≥1 point reduction in pain interference; 9.6% (95%CI,3.2-21.0) of patients achieving both these measures. Patients with peripheral neuropathic pain were more likely to achieve this primary outcome at 12-months (25.3% of patients; 95%CI,21.4-29.5) (p=.012). **Conclusions:** Patients with central neuropathic pain were less likely to achieve a meaningful improvement in pain and function compared to patients with peripheral neuropathic pain at 12-month follow-up.

A.03

Durable clinical and MRI efficacy of alemtuzumab over 6 years in CARE-MS II patients with RRMS who relapsed between Courses 1 and 2

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Background: In RRMS patients with inadequate response to prior therapy, 2 alemtuzumab courses (12 mg/day; baseline: 5 days; 12 months later: 3 days) significantly improved outcomes over 2 years (y) versus SC IFNB-1a (CARE-MS II [NCT00548405]), with durable efficacy over a 4-y extension (NCT00930553). We present 6-y efficacy (2-y core study plus 4-y extension) in patients with relapse (relapsers) between Courses (C) 1 and 2. **Methods:** Annualized relapse rate (ARR); 6-month confirmed disability worsening (CDW); MRI disease activity (Gd-enhancing lesions; new/enlarging T2 hyperintense lesions); brain volume loss (BVL; derived by relative change in brain parenchymal fraction). **Results:** 105/435 (24%) patients relapsed between C1 and C2; 33% (relapsers) versus 55% without relapse (non-relapsers) received neither alemtuzumab retreatment nor another disease-modifying therapy through Y6. ARR (Y1: 1.2) declined post-C2 (0.5), remaining low through Y6 (0.2 [0.1, non-relapsers]; 10/105 [10%] relapsed). Through Y6, patients remained CDW-free (60% [relapsers]; 75% [non-relapsers]), Gd-enhancing lesion-free (94% [relapsers]; 90% [non-relapsers]), new/enlarging T2 hyperintense lesion-free (68% [relapsers]; 69% [non-relapsers]), and MRI disease activity-free (68% [relapsers]; 69% [non-relapsers]). Alemtuzumab slowed median percent yearly BVL (Y6: -0.13% [relapsers]; -0.10% [non-relapsers]). **Conclusions:** Patients relapsing between C1 and C2 improved post-C2 through Y6. These findings support administering 2 alemtuzumab courses to achieve optimal and durable benefit.

A.04

High times? Prevalence and perceptions of marijuana use among patients with epilepsy

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Background: Despite medical advances, almost a third of people with epilepsy have medically refractory epilepsy (MRE). With failure of pharmaceutical options, patients are turning to alternative treatment options. Marijuana use in epilepsy has received extensive attention. Two recent studies evaluated the opinions of marijuana use in individuals with epilepsy, but had discrepant marijuana use rates. **Methods:** The first 200 adult patients with a known diagnosis of epilepsy seen at Hamilton General Hospital after June 1, 2017 were invited to participate. Standardized paper questionnaires gathered information about demographics, epilepsy history, and marijuana use. **Results:** One hundred forty participants returned questionnaires; 29.5% were active marijuana users; 24.5% had consumed marijuana in the past. Increased seizure frequency was significantly associated with marijuana use. There was a non-significant trend towards increased marijuana use with males and MRE. Almost half the active marijuana users noted improvement in seizure frequency. No participants experienced worsening of epilepsy with marijuana use. Side effects were common (30%), most frequent being mood. **Conclusions:** Prevalence of marijuana use among people with epilepsy is higher in our study population compared to an Australian cohort, but similar to Canadian studies. Marijuana use was significantly associated with increased seizure frequency. The majority of patients perceived benefit with regard to seizure control.

A.05

Association between timing of direct enteral tube placement and outcomes after acute stroke

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Background: The relationship between timing of direct enteral feeding tube (DET; gastrostomy/jejunostomy) placement and outcomes after stroke is unknown. **Methods:** We used the Ontario Stroke Registry and linked administrative databases to identify patients with acute stroke between 2003-2013 who received DET during hospital admission. We used multiple logistic regression and Cox proportional hazard models to determine the association between time from admission to DET placement and outcomes of severe disability at discharge (modified Rankin Scale score 4-5) and 30-day mortality after DET placement, adjusting for age, sex, co-morbidities, stroke type, stroke severity, intensive care or stroke unit admission, palliation, and hospital type. **Results:** 1,342 patients met our inclusion criteria. There was a lower hazard of 30-day mortality for each week in delay to DET placement (adjusted HR 0.89, 95%CI 0.80 to 0.99), but higher odds of severe disability (adjusted OR 1.36, 95%CI 1.14 to 1.62). Patients with DET placement within 1 week had the highest 30-day mortality compared to subsequent weeks (adjusted HR 1.59, 95%CI 1.05 to 2.4). **Conclusions:** Delayed DET placement after stroke is associated with lower 30-day mortality but greater disability. Thirty-day mortality was highest in those who received DET