a 1-month, placebo (PBO)- and active-controlled (zolpidem; not discussed here) study, and Study E2006-G000-303 (NCT02952820), a 12-month, randomized, PBO-controlled study (first 6-months), evaluated the efficacy/safety of LEM 5mg (LEM5) and LEM 10mg (LEM10) in subjects with insomnia disorder. The primary/secondary endpoints in both studies included multiple objective/subjective sleep parameters and patient-reported measures, which were assessed for concordance. Results: In both studies, statistically significant improvements with LEM5/LEM10 were reported in multiple objective and patient-reported measures versus PBO, showing a concordance of results, with observed improvements continuing through 12 months. LEM was well tolerated; most treatment-emergent adverse events were mild/moderate. Conclusions: When deciding which sleep agent to prescribe, it is important that improvement can be demonstrated in both objective and patient-reported measures. LEM treatment showed concordance among observed measures.

P.054

Older subjects with insomnia disorder and comorbid pain at baseline: response to Lemborexant

A Kaplan (Markham) JY Cheng (Nutley) M Suzuki (Tokyo) D Kumar (Nutley) M Moline (Nutley) E Pappadopulos (Nutley)*

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Background: There is a well-established reciprocal relationship between pain and poor sleep. Therefore, we evaluated whether an approved sleep-promoting drug, lemborexant (LEM), could improve sleep in older adults who reported both insomnia and pain. Methods: Study E2006-G000-304 (NCT02783729) was a 1-month, placebo (PBO)- and active-controlled study in subjects (age ≥55y) with insomnia disorder. Those reporting some/severe pain on the pain/discomfort dimension of the EQ-5D-3L at baseline were included. Subjects were randomized to placebo (PBO), LEM 5mg (LEM5), 10mg (LEM10) or zolpidem (not reported here). Changes from baseline (CFB) in objective sleep parameters latency-to-persistent sleep (LPS) and total-sleep-time (TST) were analyzed in paired polysomnograms. Results: 183/743 (24.6%) subjects in the PBO (n=55/208[26.4%]), LEM5 (n=78/266[29.3%]) and LEM10 (n=50/269[18.6%]) treatment groups reported some/extreme pain at baseline, with median LPS (minutes): 31.0, 29.4, 42.1, respectively. Respective median CFB for LPS at the beginning (Nights[NT]1/2: +2.5, –8.4, –15.8; P<0.005) was significantly larger/decreased for LEM5/LEM10 versus PBO and LEM5 at treatment end (NT29/30: –7.1, –9.9, –9.0; P=0.031). Mean baseline TST (minutes) was 335.3 (PBO), 336.3 (LEM5), 324.3 (LEM10), and mean CFB was significantly larger/increased (P<0.001) for LEM5/LEM10 versus PBO at NT1/2 and NT29/30. Conclusions: Results suggest LEM may effectively treat insomnia in older adults with comorbid pain.

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P.055

Does age matter in the CaRMS neurology match?

A Young (Winnipeg) M Ng (Winnipeg)*

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Background: The Canadian Resident Matching Services (CaRMS) collects comprehensive data on residency applicants. However, match outcomes by age were not reported. It was unclear whether older applicants found it more difficult to match to the specialties of their choice, i.e. does age influence match? We ask in particular, does age affect the neurology match? Methods: In response to written request, CaRMS provided pre-pandemic age data for 2015-2019 inclusive, divided into group 1 (30 or younger) and group 2 (31-40 inclusive). Results: In 2019, 39 of the 69 group 1 and 6 of the 23 group 2 neurology applicants were matched into neurology (odds ratio (OR)=2.2|p=0.01). In contrast, urology (OR=6|p=0.001) had the worst odds and family medicine (OR=1.2|p=0.002) had the best odds for older applicants in 2019. Average OR (2015-2019) was 1.6 for neurology, 3.1 for urology, 1.3 for family medicine, and between 1.3 and 3.1 for nearly all other specialties. Conclusions: Older neurology applicants were less likely to match than younger peers while match probability was statistically significantly lower in nearly all specialties for older applicants.

P.056

Dual-energy CT for differentiating intracerebral hemorrhage from Contrast Extravasation after Acute Ischemic Stroke Intervention (DECT-ICH)

A Siddiqi (Winnipeg) A Trivedi (Winnipeg) S Alcock (Winnipeg) J Shankar (Winnipeg)*

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Background: Thrombolysis (tPA) and endovascular thrombectomy (EVT) are interventions for acute ischemic stroke (AIS) that can be accompanied by intracerebral hemorrhage (ICH), which can alter the patient's management, or contrast extravasation (CE), which is relatively benign. Previous retrospective studies have shown that dual-energy CT (DECT) is significantly more accurate for differentiating ICH from CE compared to conventional, single-energy CT (SECT). We are performing a prospective study to investigate this question. Methods: Our primary outcome is the sensitivity and specificity of DECT in differentiating ICH from CE. In AIS patients who receive intervention, we will be performing a DECT scan at the same time as the standard-of-care SECT scan at 24 hours post-intervention. In patients who have a hyperdensity on CT, a repeat scan will be done at 72-hours, which will be used as the gold-standard to determine if the hyperdensity was ICH or CE. Results: We expect that DECT will be significantly more sensitive and specific for differentiating ICH from CE compared to SECT.