

psychiatric diagnosis and more self-reported alcohol consumption in the “worried well” group. The “worried well” and “Alzheimer’s Disease” comparison had the same significant differences as the “worried well” and “other” comparison. *Conclusions:* We observed a pattern of differences between the “worried well” patients and those with cognitive disease. Taking multiple factors into account when evaluating a patient may help with clinical decision making.

B.07

Differences between Indigenous and non-Indigenous patients referred to a rural and remote memory clinic

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Background: Jacklin et al. (2013) described a rising incidence and a younger onset of dementia in Albertan First Nations compared to non-First Nations patients. Canadian research is limited in Indigenous patients with dementia, leaving it difficult to understand factors contributing to the differences in incidence and prevalence. *Methods:* 375 patients (41 Indigenous) was seen at the clinic. The questionnaire given during initial assessments were reviewed and differences between groups (non-Indigenous patients versus Indigenous) were assessed. *Results:* Compared to the non-Indigenous patient, Indigenous patients were younger ($p=0.007$), were more likely to be female ($p=0.033$) and had less education ($p=0.055$). They were less likely to live solely with a partner ($p<0.001$) and more likely to have a daughter as caregiver ($p=0.004$). The Indigenous patients were more likely to smoke ($p<0.001$). Although no differences in diagnosis of mental health disorders were seen ($p=0.735$), the Indigenous patients scored significantly higher on the CES-D ($p<0.0001$). *Conclusions:* This comparison highlights differences potentially affecting the health of Indigenous patients. Acknowledging these differences is critical to individualized patient care. Further research is required to explore how these factors affect dementia disease course and treatment, and how these factors play a role in the differences in incidence and prevalence demonstrated in previous studies.

CNSS CHAIR’S SELECT ABSTRACTS

C.01

Cystic Vestibular Schwannomas respond best to radiosurgery

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Background: Vestibular Schwannomas (VS) have a well-documented response to Gamma Knife® Stereotactic radiosurgery (SRS). However, there is limited data available regarding the volumetric response of cystic tumors. This report correlates the radiographic appearance of VS before radiosurgery with the delayed volumetric response. *Methods:* This study reviewed 219 VS patients between 2003 and 2013. Patients were treatment naïve and had a significant extracanalicular tumor volume. MRI at SRS identified;

42 contrast enhancing macrocystic tumors, 45 contrast enhancing microcystic tumors, and 132 homogeneously enhancing tumors with no intra-tumoral cyst formation. The median follow-up was 49.1 months. The median tumor volume was 2.6cm³ (0.70-16.1cm³) and the median dose was 12.5Gy (11-13Gy). *Results:* The actuarial tumor control rate was 99.4% at 2-years and 96.4% at 5-years. A volumetric reduction of >20% occurred in 85.4% of macrocystic tumors, 76.1% of microcystic tumors and 62.8% of homogeneously enhancing VS. The median volume decrease per year for macrocystic, microcystic and homogenous tumors was 17.2%, 7.5% and 7.9% per year respectively ($p<0.001$). Serviceable hearing was maintained in 61.5% of patients that had Gardner-Robertson grade I-II hearing. *Conclusions:* SRS provided VS tumor control in >95% of patients, regardless of radiographic characteristics. Tumor volume regression was most evident in patients with cystic tumors.

C.02

Delayed new-onset hormone dysfunction following complete and incomplete resection of nonfunctioning pituitary adenomas

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Background: Post-operative delayed hormone dysfunction (DHD) in patients with nonfunctioning pituitary adenomas (NFPA) is highly variable and is predicted based on limited evidence. This study was undertaken to assess the likelihood of developing new DHD and its relation to the extent of tumor resection and recurrence. *Methods:* Four hundred fifty-five prospectively collected patient files were reviewed from our Program’s database. Inclusion criteria: NFPA; underwent surgery; and minimum follow-up of two years. Tumor recurrence was correlated with DHD (starting one year post-operatively) based on standardized annual imaging and hormone testing. *Results:* Eighty-nine patients met our inclusion criteria: 39 males and 50 females; mean follow-up was 4.3yrs (ranging from 2 to 11yrs). With no post-op residual tumor, the probability of developing DHD was only 7% by six years; no patient in this group developed DHD after three years of follow-up. In contrast, by six years, the probability of DHD was 33% in patients with residual stable tumor, and 54% in those with tumor recurrence/growth. *Conclusions:* By six years, approximately one third of patients with incomplete resection, and over half with tumor regrowth, will likely develop DHD. In contrast, the risk of DHD with complete tumor resection is <10% and, when seen, occurs within three years of surgery.

C.03

Surgical clipping or endovascular coiling for unruptured intracranial aneurysms: a pragmatic randomized trial

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Background: Unruptured intracranial aneurysms (UIAs) are treated using endovascular treatment or microsurgical clipping. The safety and efficacy of treatments have not been compared in a randomized trial. *Methods:* We randomly allocated clipping or coiling to patients with 3-25mm UIAs judged treatable both ways. The primary