patients. Bed rest and spine immobilisation by bracing is prescribed to decrease pain but also to prevent those complications. There is currently no consensus about the best immobilisation method to follow in VO. French guidelines recommend bracing for all patients whereas recently published American recommendations did not even mention spine immobilisation.

**Objectives:** To describe the type and duration of prescription of spine immobilisation during VO.

**Methods:** A prospective multicenter study was performed in 7 French centres. All patients with VO were followed prospectively for neurological complications, imaging findings, type and duration of immobilisation were reported. We present here the data of our study after 3 months of follow-up.

**Results:** To date, 79 patients completed 3 months follow-up. Medium age was 67 ±15 years old with 66% of males. Mean duration of symptoms before diagnosis was 27 days, IQR, 7–18. 43% of patients had an abnormal neurological exam at baseline: 18 patients (23%) had minor neurological signs (sensory loss, radiculopathy or pyramidal syndrome), and 10 (12%) had major neurological signs (motor deficit or cauda equine syndrome). During hospital stay, 5 patient developed major neurological signs (median 5 days after diagnosis) and 7 minor neurological signs (median 6 days after diagnosis). Half of the patients with abnormal neurological exam at baseline had functional sequelae at 3 months. On MRI, 17% of patients had epidural phlegmon, 20% had anterior effacement of subarachnoidal space, and 16% had involvement of cervical spine. All these MRI signs were significantly associated with major neurological complications (p = 0.004, p = 0.004 and p = 0.002, respectively).

Median duration of bed rest was 9 days (IQR 7–18). Overall, only 60% of patients have been immobilised by bracing (90% of rigid bracing). Median duration of prescription was 8 weeks, IQR, 6–12. Patients who did not receive spine immobilisation had all a lumbar involvement, a normal neurological examination at baseline. None of them developed secondary neurological complications. They were no significant difference in age (72±16 versus 65±15 years old), sex or duration of the symptoms between patients who have been immobilised or not.

**Conclusions:** Neurological complications occurred in 35% of our patients as published in previous VO cohort. Interestingly, 40% of our patients were not treated with bracing. They all had lumbar involvement and normal initial neurological examination. None of them developed secondary neurological complications. Bed rest without bracing might be the best therapeutic option for these patients, preventing the morbidity associated with bracing.

**REFERENCE:**


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**SA10400 INFECTIOUS SPONDYLODISCITIS: 7-YEAR ANALYSIS OF CLINICAL AND PROGNOSTIC VARIABLES IN A TERTIARY HOSPITAL**

J. Fragè1, R. Gonzalez Mazario1, E. Labrador Sanchez2, E. Grau Garcia1, K. R. Arevalo Ruales1, M. de la Rubia Navarro1, C. Alcaraz Escandell1, L. Gonzalez Puig1, J. Ivorra Cortes1,3, I. Martinez Cordellat1, I. Canovas Olmos1, C. V. Inmaculada1, C. Najera Herranz1, C. Feced Olmos1, R. Negueroles Albiach1, J. E. Oller Rodriguez1, F. M. Ortiz Sanjuan1, V. Fonse Ferrer4, M. Tasias Pitarach5, E. Calabuig Muñoz7, M. Salavert Lleti7, J. A. Roman Ivorra1,2,1, *Rheumatology, Hospital La Fe, Valencia, Spain*

**Background:** Spondylodiscitis is an infectious disease of the vertebral body and intervertebral space, the early diagnosis and treatment is essential to give the patient the best chance of a good outcome, but these are often delayed because it tends to present nonspecific manifestations.

**Objectives:** To analyse cases of Spondylodiscitis and identify poor prognosis variables.

**Methods:** A retrospective observational study, included all adult patients with confirmed infectious spondylodiscitises between January 2010 and December 2017. Demographic features, concurrent disease, clinical history, laboratory findings, microbiological diagnosis, radiological data and clinical outcome were compiled from the medical history management software. Statistical analysis was performed with the software R (version 3.3.2).

**Results:** We included 87 patients with a mean age of 62.05 (16.94) years old. Males predominated (69%). Almost 31% patients presented of a level of immunosuppression (immunosuppression treatment, cirrhosis, HIV infection, solid organ transplantation). The average time with axial pain was 74 (87.65) days. Mean length of hospital stay was 34.24 (34.3) days and readmission rate was 34.9%. Most of patients showed high CRP levels at their admission, with an average value of 88.92 (84.58) mg/l, it was not correlated with worse prognosis. Underlying endocarditis proportion was 11.5%, Blood cultures were positive in 29 patients (33.3%), it was correlated with hospital stay (p=0.03). 51 patients had pustular aspiration and intervertebral biopsy with microbiologic findings diagnosis in 30 patients (58.8%): 42.5% patients had an identifiable gram + bacteria (37.8% Streptococcus genere), 13.7% a Gram- bacteria, Mycobacterium tuberculosis in 8% and fungi infection (all Candida spp) in 3.4%. 38% of patients showed vertebral destruction on MRI; 17.4% cord compression and developed neurological complications (8 of them paraparesis). 18.4% of patients required further surgical procedures. Furthermore, vertebral destruction was statistically correlated with epidural abscess (p=0.006). Almost 6% of patients died in the following year after diagnostic.

**Conclusions:** Delay in diagnosis is an important issue in Spondylodiscitis patients. Higher complications rates are mainly in relation to greater vertebral destruction. Underlying infectious endocarditis was described in a small proportion of patients in contrast to other studies. Presence of epidural abscess was also