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 protocol 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: 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. Median age was 67 ±15 years old with 66% of males. Median duration of symptoms before diagnosis was 27 days, IQR. ¹¹⁻⁴⁰ 37 patients (47%) had staphylococcal infection.

35% of the 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 subarachnoid 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.

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SAT0399 CHIKUNGUNYA FEVER IN KARACHI: CLINICAL AND LABORATORY FEATURES AND FACTORS ASSOCIATED WITH PERSISTENT ARTHRALGIA

H. Alam, T.P. Umer, L. Nazir. *Rheumatology, Liaquat National Hospital, Karachi, Pakistan*

Background: Chikungunya virus (CHIKV) is an alphavirus transmitted by mosquito vectors. ¹ Acute infection lasts for 1–10 days and is characterised by abrupt onset of fever and severe arthralgia. Painful polyarthralgia is the symptom causing serious economic and social impacts on individuals and the affected communities. ² In a study conducted by Schilte C et al, 60% of CHIKV-infected patients suffered from arthralgia, 36 months after acute infection. ³ Non-salicylate analgesics and non-steroidal anti-inflammatory drugs (NSAIDs) are most commonly used for symptomatic relief. ⁴ There is lack of local data on CHIKV and its after effects. By determining the clinical and laboratory features associated with CHIKV and persistent arthralgia, it will help us in early diagnosis, and improved outcomes in our population.

Objectives: To study clinical and laboratory features associated with persistent arthralgia in patients with chikungunya fever

Methods: This observational study was conducted at the Rheumatology Clinic of Liaquat National Hospital, Karachi. It comprised of collected data of patients who presented with arthralgias and positive chikungunya serology. Detailed history, examination and laboratory investigations were recorded in a pre-designed structured proforma and SPSS21 was used for statistical analysis.

Results: We had 52 patients out of which 28.8% were males and 71.2% were female, mean age being 45±5 years. Mean duration of arthralgia was 2.6 months. Pre-existing rheumatologic conditions were RA in 1.9% while SLE in 1.9% of the patients. Out of the total 9.6% were hospitalised due to complications like encephalitis, septic arthritis. Symmetrical arthralgia and asymmetrical was described

in 76.9% and 23.1% of cases respectively. Small joint involvement was in 21.2%, large joint in 20.8% while both small and large involvement was seen in 48.1% of patients. Morning stiffness of greater than ½ hour was described in 63.5% of cases. Elevated ESR, CRP was seen in 69.2% and 59.6% cases, respectively. Patients were either given NSAIDs (34.6%), steroids (57.7%), or both (7.7%). Steroid was usually given in the form of a single intra muscular methylprednisolone 120 mg dose. In total 85.7% of patients improved after receiving steroids. While in group receiving NSAIDs only, improvement was seen 7.1% of total cases, and persistent arthralgia was seen in 88.9% of same group.

Conclusions: Chikungunya viral arthralgia has constituted a major disease and socioeconomic burden in our society in a relatively short span of time. Studies including our show it to be a great mimicker of inflammatory arthritis, and stresses the need to differentiate it, as history, clinical examination and lab parameters show quite similarity. Prompt treatments through steroids have shown great response in symptoms.

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SAT0400 INFECTIOUS SPONDYLODISCITIS: 7-YEAR ANALYSIS OF CLINICAL AND PROGNOSTIC VARIABLES IN A TERTIARY HOSPITAL

J. Frago¹, R. Gonzalez Mazario¹, E. Labrador Sanchez¹, E. Grau Garcia¹, K. R. Arevalo Ruales¹, M. de la Rubia Navarro¹, C. Alcañiz Escandell¹, L. Gonzalez Puig¹, J. Ivorra Cortes^{1,2}, I. Martinez Cordellat¹, I. Canovas Olmos¹, C. V. Inmaculada¹, C. Najera Herranz¹, C. Fedec Olmos¹, R. Negueroles Albuixech¹, J.E. Oller Rodriguez¹, F.M. Ortiz Sanjuan¹, V. Fornes Ferrer³, M. Tasis Pitarch⁴, E. Calabuig Muñoz⁴, M. Salavert Llet⁴, J.A. Roman Ivorra^{1,2}. ¹*Rheumatology, Hospital La Fe*; ²*Rheumatology, UCV Medical School*; ³*Biostatistics Unit, IIS La Fe*; ⁴*Infectious Diseases Unit, Hospital La Fe, Valencia, Spain*

Background: Spondylodiscitis is an infectious disease of the vertebral body and intervertebral space, the early diagnosis and treatment are 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 spondylodiscitis 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 clinical 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 puncture-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

correlated with vertebral destruction, for this reason, patients with this finding should be more carefully follow-up.

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SAT0401

RISK OF HOSPITAL ADMISSION DUE TO SEVERE INFECTION IN PATIENTS UNDER TREATMENT WITH ANTI-TNF DRUGS: DATA FROM A LOCAL REGISTRY

J. Rosas¹, M. Pucciarelli², J.M. Senabre-Gallego¹, J.A. García-Gómez³, J. Ena², G. Santos-Soler¹, X. Barber³, E. Salas¹, A. Pons-Bas¹, C. Cano¹, E. Ivars¹, M. Lorente¹ on behalf of AIRE-MB Group. ¹Rheumatology Department; ²Internal Medicine Department, Hospital Marina Baixa, Villajoyosa (Alicante); ³COI, Miguel Hernández University, Elche, Spain

Objectives: To Know characteristics of patients treated with anti-TNF, who suffered infections that forced hospital admission.

Methods: Prospective observational study in patients treated with anti-TNF, during 1/1/2000 to 12/31/2017, followed up in the Rheumatology Section. General data of patients (age, gender), of disease (diagnosis and time of evolution, type of anti-TNF, time in anti-TNF, concomitant treatment with DMARD), regarding the presence of severe infection, defined as infection that required hospital admission (time in anti-TNF to infection, location of infection, days of admission, mantoux/IGRAS and vaccinations prior to the start anti-TNF treatment) was collected. The admission decision was made by Emergency Department of centre or Rheumatology.

Results: Of 442 patients with anti-TNF, 44 (9.6%) patients had at least one hospital admission due to severe infection. 59% were women, with mean age 64±16.72 years, 22–88 21.25±4.02 years of disease evolution. A mantoux/IGRAS was performed prior anti-TNF. Diagnosis was: rheumatoid arthritis (RA): 25 (57%), ankylosing spondylitis (AS): 12 (27%), psoriatic arthritis (PSA): 5 (11%) and juvenile idiopathic arthritis (JIA): 2 (5%). The mean time of treatment with anti-TNF is 5.6 ±4.5 years. Adalimumab received 24 (55%) patient, infliximab 8 (18%) patients, etanercept 6 (14%) patients, golimumab 5 (11%) and 1 (2%) certolizumab.

Of the 55 confirmed infections: non-pneumonic infection in 13 (24%) patients, pneumonia: 10 (18%), septic arthritis: 6 (11%), septic shock and/or bacteremia: 6 (11%), abscess: 4 (7%), urinary infections: 4 (7%), cellulitis: 3 (5%), cutaneous leishmaniasis: 3 (5%), acute gastroenteritis: 2 (4%), surgical wound infection: 1 (2%), cutaneous infection: 1 (2%), Septic bursitis: 1 (2%), gonorrhoea: 1 (2%). The mean time of hospital admission was 9.76 days. Three (7%) patients presented the infection within a year of starting treatment.

The rate of severe infection x100 patients/year of exposure is 2.01 (1.47–2.67). The odd ratio of admission for infection of 3.67 (1.11–4.87, p=0.03). The risk of admission for infection in patients with peripheral arthritis (RA, PSA, JIA) is 2.42 (1.21–3.11) times higher than in patients with AS (p=0.012).

In the table 1, the Odd ratio of income for infection distributed by anti-TNF drug is shown.

Anti-TNF	N° patients	Odds ratio (IC 95%)
Infliximab	101	8.01 (4.99–12.05)
Golimumab	82	5.68 (2.95–9.73)
Certolizumab	33	3.25 (0.54–10.03)
Adalimumab	239	3.03 (2.08–4.22)
Etanercept	188	2.44 (1.48–3.76)

Conclusions: 1. The severe infection rate x100 patients/year of exposure is 2.01 and the prevalence is 9.6%. 2. The majority of severe infection occurred late, after more than 1 year of treatment. 3. The most frequent infection were those of respiratory origin, followed by sepsis or bacteremia and septic arthritis. 4. Etanercept has presented the lowest rate of severe infection. 5. Patients with AS have a lower risk of severe infection than patients with chronic peripheral arthritis.

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SAT0402

LEISHMANIASIS IN PATIENTS ON TUMOUR NECROSIS FACTOR INHIBITORS TREATMENT

L. Montolio Chiva¹, E. Valls Pascual¹, D. Ybañez García¹, A. Martínez Ferrer¹, M. Fernández Matilla², J. Lluch Pons³, X. Juanola Roura³, J. Marcoval Caus⁴, M.-I. García Briz⁵, J.M. Paredes Arquiola⁶, I. López Cruz⁷, A. Salazar Cifre⁸, M. Aguilar Zamora¹, A.V. Orenes Vera¹, A. García Sendra¹, V. Núñez Monje¹, I. Torner Hernández¹, J.J. Alegre Sancho¹. ¹Rheumatology, Hospital Dr Peset; ²Rheumatology, Hospital Arnau de Vilanova, Valencia; ³Rheumatology; ⁴Dermatology, Hospital de Bellvitge, Barcelona; ⁵Dermatology; ⁶Digestive; ⁷Internal Medicine, Hospital Dr Peset; ⁸Epidemiology, Public Health Center, Valencia, Spain

Background: Tumour necrosis factor (TNF) plays a major role in defense against leishmaniasis. Despite wide use of TNF α inhibitor (anti-TNF) for several diseases, leishmaniasis has been a rare infectious complication so far in these patients. Recently, an increased incidence has been noted.

Objectives: To describe a recent multicenter case series of leishmaniasis in patients with chronic inflammatory diseases treated with anti-TNF.

Methods: We reviewed the clinical history of a multicentric series of patients with chronic inflammatory diseases treated with anti-TNF, who were diagnosed with leishmaniasis between January 2013 and December 2017. Patients came from Rheumatology, Digestive and Dermatology departments of several hospitals in Valencia² and Cataluña¹ region. Demographic (age, sex) and clinical (inflammatory disease, comorbidities, current treatment, year of infection and leishmaniasis form) variables were collected. Anti-TNF withdrawal, subsequent reintroduction and recurrence rate were recorded in two hospitals. Biologic drug dispensation trends from 2013 to 2016 and epidemiological data published by the Regional Ministry of Health of Valencia for the area where cases were most incident were analysed.

Results: 25 cases of leishmaniasis in patients treated with immunomodulators were identified: 7 on DMARD, 1 on tocilizumab and 17 on anti-TNF (7 infliximab, 4 adalimumab, 3 golimumab, 2 certolizumab, 1 etanercept). Regarding patients on anti-TNF, 2 cases were collected in 2014, 4 in 2015, 4 in 2016 and 7 in 2017. Three patients developed the visceral form, 13 the cutaneous form and 1 presented visceral and cutaneous involvement. Seven patients were males and 10 females, with an average age of 50 (SD14) years. One patient presented rheumatoid arthritis, 4 psoriatic arthritis, 1 undifferentiated spondyloarthritis, 2 ankylosing spondylitis, 1 uveitis, 6 Crohn's disease and 2 ulcerative colitis. Six patients presented other chronic disease (1 latent tuberculosis, 1 pyoderma gangrenosum, 1 psoriasis and 3 diabetes mellitus). In two hospitals (15 patients), anti-TNF treatment was withdrawn in 10 cases, and it was reintroduced after treating the infection in 5 cases. No infection recurrences have been identified. Focusing on the area with the highest incidence of cases, despite the increase in anti-TNF use over the last years, its consumption was not parallel to the rise of leishmaniasis cases reported.

Conclusions: the disproportionate increase of leishmaniasis cases in patients with anti-TNF suggests the necessity to investigate and control other possible factors involved.

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SAT0403

BLOOD B CELL SUBSET PROFILE DISTURBANCE IN WHIPPLE'S DISEASE

M. Le Goff¹, D. Cornec², D. Guellec¹, T. Marhadour¹, V. Devauchelle-Pensec¹, S. Jousse-Joulin¹, M. Herbette¹, J.M. Cauvin³, C. Le Guillou³, Y. Renaudineau⁴, J.-O. Pers⁴, A. Saraux¹. ¹Rheumatology, CHU Brest and Université Bretagne Occidentale; ²Rheumatology, CHU Brest and UMR 1227 Université Bretagne Occidentale; ³DIM; ⁴Immunology, CHU Brest and Université Bretagne Occidentale, Brest, France

Background: Technological advances have improved phenotypical characterisation of blood cells, and flow cytometry is currently used in haematology, infectious disease, systemic auto-immune diseases. Abnormalities of blood B cell subset profile might provide a useful diagnostic tool in systemic auto-immune diseases, especially for primary Sjögren's Syndrome¹ in which the activated B cells to memory B cells ratio is increased. Nevertheless, we observed that some patients suffering from chronic infection had lymphocytes disturbances similar to those observed in primary Sjögren's Syndrome.

Objectives: Whipple's disease (WD) is a rare, systemic, disease caused by intracellular gram positive bacterium, *Tropheryma Whipplei* (TW). No previous study evaluated the role of B cells in WD. The aim of this study was to analyse whether the circulating blood B cell subset disturbances is characteristic of WD.