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

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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. Etarnecept 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

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Background: Tumour necrosis factor (TNF) plays a major role in defense against leishmaniasis. Despite wide use of TNFα 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 Valencia[2] and Cataluña[1] region. Demographic (age, sex) and clinical (inflammatory disease, comorbidities, current treatment, year of infection and leishmaniasis form) variables were collected. Anti-TNF withdraw, 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 spondyloarthropathy, 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 indentified. 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

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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 Syndrome[1] 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'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.