DAA and reached complete viral eradication, at 3 time points: before starting DAA (pre-DAA), after completing DAA (post-DAA), 52 weeks after completing DAA (52w). Additionally, a population of 9 patients with the same disease (mean age 65 yrs, female 77%, mean disease duration 9 yrs) but treated with one or more cycles of RTX prior receiving DAA, was analysed at the same timepoints and additionally before starting RTX(pre-RTX). At each time point clinical data (presence/absence of purpura, neuropathic manifestations, arthralgia, fatigue, nephritis) and biochemical parameters (% cryoglobulins, C3, C4 and RF) were recorded. The change in clinical and biochemical parameters at different timepoints were evaluated.

Results: Among patients treated with DAA only, the prevalence of clinical manifestations before starting treatment was the following: purpura 31%, neuropathic manifestations 52%, arthralgia 28%, fatigue 14%, nephritis 3%. We observed a significant reduction in purpura after treatment (pre-DAA vs post-DAA=31% vs 13%, $p=0.044$) that persisted at 52w (pre-DAA vs 52w=31% vs 0%, $p=0.004$). This in parallel with a significant reduction in the level of cryoglobulins (pre-DAA vs 52w=3.99±5.28 vs 1.6 ±1.7, $p=0.029$ and pre-DAA vs 52w=3.99 ± 5.28 vs 0.92 ± 1.75, $p=0.008$). Among patients pre-treated with RTX, the prevalence of clinical manifestations before starting RTX was: purpura 78%, neuropathic manifestations 100%, arthralgia 44%, fatigue 50%, nephritis 22%; and before starting DAA was: purpura 22%, neuropathic manifestations 100%, arthralgia 0%, fatigue 0%, nephritis 0%. A significant reduction in the rate of purpura (pre-RTX vs pre-DAA=78% vs 22%, $p=0.009$) and arthralgia (44% vs 0%, $p=0.012$) after RTX treatment was observed, but no difference in any clinical parameter when comparing pre-RTX with post-DAA and 52w. No significant change in any of the serological parameter was observed.

Conclusion: DAA treatment is associated with rapid and sustained decrease in the level of cryoglobulins and related clinical improvement, specifically purpura. Patients who had been pre-treated with RTX showed clinical improvement in terms of purpura and arthralgia, albeit transient; subsequent treatment with DAA did not result in any immediate or long term additional clinical benefit.

REFERENCES

- [1] Mazzaro C. Clin Exp Rheum 2017.

Disclosure of Interests: Maria Di Cicco: None declared, Davide Antonio Filippini: None declared, Federica Filippini: None declared, Laura Belloli: None declared, Valeria Campanella: None declared, Cinzia Casu: None declared, Michel Chevallard: None declared, Marina Muscarà: None declared, Mariaeva Romano Speakers bureau: janssen, Emanuela Schito: None declared, Elisa Verduci: None declared, Massimo Puoti: None declared, Maria Vinci: None declared, Oscar Massimiliano Epis Speakers bureau: BMS

DOI: 10.1136/annrheumdis-2019-eular.7781

SAT0461

VERTEBRAL OSTEOMYELITIS IN THE IMMUNOSUPPRESSED PATIENTS

Jorge Juan Frago-Gil¹, Roxana Gonzalez Mazario¹, Jose Ivorra Cortés¹, Francisco Miguel Ortiz Sanjuan¹, Elena Grau Garcia¹, Cristobal Pavez Perales¹, Marta De la Rubia Navarro¹, Inmaculada Chalmeta Verdejo¹, Luis Gonzalez Puig¹, Isabel Martínez Cordellat¹, Rosa Neguerolos Albuixech¹, Cristina Alcañiz Escandell¹, Jose Eloy Oller Rodríguez¹, Elvira Vicens Bernabeu¹, Carmen Nájera Herranz¹, Inés Cánovas Olmos¹, María Tasisas Pitarch², Eva Calabuig Muñoz², Miguel Salaveri Lletí², Jose Andrés Román Ivorra¹. ¹Rheumatology Department. HUP La Fe, Valencia, Spain; ²Infectious Diseases Unit. HUP La Fe, Valencia, Spain

Background: Vertebral Osteomyelitis (VO) is an infectious disease that could involve intervertebral space (discitis). Its incidence is raising for several reasons, such as the increasing number of patients on immunosuppressive therapy. The treatment includes long term antibiotic, that should be initiated after biopsy (if possible) and sometimes, further surgery is needed¹.

Objectives: To analyze the influence on prognosis of detection of OV in immunosuppressed (IS) patients.

Methods: Single center retrospective observational study including IS adult patients diagnosed of VO based on the combination of clinical presentation with either a definitive bacteriologic diagnosis or pathological and/or imaging studies from January 2010 to January 2019. Demographic features, concurrent diseases, clinical history (length of pain and fever prior to admission), laboratory findings, microbiological diagnosis and radiological data were compiled. We considered as IS patients those who had rheumatic or inflammatory bowel disease undertaking immunomodulatory drugs, solid organ transplantation receptors, patients with an active

malignancy or Human Immunodeficiency Virus (HIV) infected. Clinical and radiological history of lumbar stenosis or disc herniation was considered as prior spine pathology. Surgical infections were excluded. We considered deaths attributable to PVO those which were directly caused by the infectious picture and/or its complications during the next year after diagnosis.

Results: Eighteen of 122 patients with VO (21.96%) were IS. Basal demographic and clinical features are exposed in table 1. Detailed data about the cause of the IS is provided separately in table 2. Duration of pain prior to diagnosis had a median of 30 days (15.5, 55). C reactive protein showed a median value of 65.2mg/L (19.32, 153.9) and Erythrocyte Sedimentation Rate mean value was 80.57mm/H (31.75). MRI was the imaging technique most often used for diagnosis (83.33%), followed by CT-scan (16.67%). The region most frequently affected was lumbosacral spine (44.44), then dorsal (33.33%) and finally cervical (22.22%). Some abscess (epidural or paravertebral) was detected in 16 patients (88.89%) close to non-IS patients (90.38%). Worst data concerning vertebral destruction was observed (66.67% in IS group against 49.04 in non-IS, $p=0.3$) and cord compression (61.11% versus 26.92% respectively, $p=0.05$). Fifteen patients underwent CT guided biopsy (83.33%) with prior antibiotic exposure in 11 of them. Median exposure was 4.5 days (3, 8.75). Delay from admission to procedure had a median value of 6 days (3.5, 9). Culture was positive in 53.33% of cases. In 10 patients, the picture was attributed to Gram+ (55.56%), in other 2 cases Gram- (11.11) and 1 case of tuberculosis (5.56). In 5 cases (27.78%) final pathogen was unknown. Four patients (22.22%) required further surgery and 2 patients (11.11) died, similar than non-IS group, 11.54%.

Conclusion: In general terms, data about imaging is worse in IS patients and higher proportion of cervical spine involvement was also noted. Although, early intervention (diagnosis, puncture guided biopsy and treatment) seems to be protective against a bad outcome, since IS patients showed similar prognosis (further surgical procedures and death) than non IS patients. To sum up, new onset back pain in a IS patient, should be thoroughly studied so as to consider a VO as soon as possible.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.6621

SAT0462

INTEREST OF FOLLOW-UP IMAGING EXAMINATIONS IN PATIENTS WITH PYOGENIC VERTEBRAL OSTEOMYELITIS: A RETROSPECTIVE STUDY

Sophie Hecquet, Kevin Bouiller, Frank Verhoeven, Clément Prati, Daniel Wendling, Catherine Chirouze. Centre hospitalier régional universitaire de Besançon, Besançon, France

Background: Systematic follow-up imaging in patients with pyogenic vertebral osteomyelitis (PVO) is widespread. However, it is discussed, and there is no recommendation.

Objectives: Evaluate the interest of follow-up imaging examinations in patients with pyogenic vertebral osteomyelitis

Methods: We conducted a retrospective cohort analysis of patients with PVO who had both baseline and follow-up imaging results available in a French university hospital during the period of 2010-2018. We have classified the follow-up images into two groups, improvement/stability and deterioration, compared with the baseline findings. For each patient, we compared their imaging follow-up to their clinical-biological condition assessed at the same time.

Results: We have collected 80 patients. The median age was 71 years [32-89], 46 men, 13 patients had a history of spinal surgery. The most frequently reported germ was methicillin-sensitive staphylococci and the level of spinal involvement was predominantly lumbar. A Computerized Tomography (CT) was performed in 64% and a Magnetic Resonance Imaging (MRI) in 85% at the time of diagnosis. We identified 89 follow-up images, 58 MRIs, 31 CTs. The median delay of realisation was 85 days [11-364]. Soft tissue infiltration was observed in 50 patients compared to 26 on follow-up images but 3 were new. Similarly, 24% of the initial images had epiduritis compared to 16% during follow-up, 3% had appeared secondarily. There were 12% initial erosions described compared to 25% at follow-up. Of the 33 patients with clinical and biological recovery, 67% of follow-up images were classified as improving/stable and 33% as worsening (new abscesses (n=3), extension of soft tissue infiltration (n=2) and/or epiduritis (n=2) or appearance of new locations (n=2)). Among the 37 patients considered as unhealed, 87% of follow-up images were classified as improving/stable and 13% as worsening (new abscesses (n=1), extension of soft tissue infiltration (n=1) and/or epiduritis (n=1) or appearance of new locations (n=1)).