are uncommon. Several factors are associated with a predisposition to infections in patients with Systemic Lupus Erythematosus (SLE).

Objectives: To describe and analyze all documented cases of cellulitis or fasciitis caused by SPN in SLE patients.

Methods: In the framework of the study of a 24-years-old woman that during the SLE onset presented left tight cellulitis and fasciitis caused by SPN, a systematic review was conducted (until September 2018). The search included terms to identify any SPN infection in SLE patients and all those articles that reported cellulitis or fasciitis were selected (Table 1).

Table 1. flow chart.

Search: "Lupus Erythematosus, Systemic"[Mesh] AND "Streptococcus pneumoniae"[Mesh] OR "Pneumococcal Infections"[Mesh] (filter "humans", "english", "spanish").
Total searched articles: 313
- Medline 72, Embase 241, Cochrane 0.
- Duplicated 23.
- Excluded by: title 248, abstract 21, text 13.
- Selected: 8
Manual included articles: 1.

Results: A total of 313 articles were obtained. Eight of them (1-8) and 1 article identified in a manual search (9) described a total of 15 cases presenting SLE and cellulitis or necrotizing fasciitis caused by SPN; our case is the 16th described.

Documented infections (n=16):

- Cellulitis (n=8): neck, face or chest (n=5, 62.5%); extremities (foot or hand) (n=2, 25%); breast (n=1, 12.5%).
- Fasciitis (n=8): neck, face or chest (n=5, 62.5%); thighs (n=3, 37.5%).

Description of the documented cases:

- Demographic characteristics (n=13): female sex (n=11, 85%); <30 years of age at the moment of the infection (n=11, 85%).
- Time of SLE evolution at the moment of the infection (n=9): ≤ 1 month (n=3, 33.3%); ≤ 3 years (n=3, 33.3%); ≤ 8 years (n=3, 33.3%).
- Associated conditions (n=12): previous high doses of prednisone (n=5, 45%); recent respiratory symptoms (n=4, 33.3%); renal insufficiency (n=2, 16.6%); previous SPN infections (n=1, 8.3%); recent surgery in the affected area (n=1, 8.3%).
- Microbiological diagnosis (n=12): blood cultures (n=11, 91.6%); other cultures (n=5, 41.6%).
- Treatment (n=12): beta-lactams (n=12, 100%); intensive care support (n=6, 50%); surgical debridement (n=5, 41%).
- Outcome (n=15): death (n=3, 20%); recurrent SPN infections (n=2, 13.3%).

Conclusion: • - Pneumococcal cellulitis and fasciitis in SLE were predominantly presented in young women and in a high rate of cases during the disease onset.

- Almost half of the cases were previously treated with high doses of steroids. Nevertheless, no other potential predictors of pneumococcal cellulitis or fasciitis were identified; in addition, only one patient presented a previous surgery in the affected anatomical area, previous trauma were not described in any case, and a low number of cases reported associated respiratory symptoms. This supports the importance of the intrinsic immune dysregulation in SLE patients.
- Pneumococcal cellulitis and fasciitis in SLE patients present poor prognosis, requiring intensive care support and surgical debridement in a high rate of cases, and presenting a fatal outcome in a fifth of them.

REFERENCES

- [1] DiNubile; 1991.
- [2] Hill; 1997.
- [3] Isik; 2007.
- [4] McDonald; 1993.
- [5] Page; 2003.
- [6] Patel; 1994.
- [7] Sabio; 2006.
- [8] Sánchez; 2016.
- [9] Kamran; 2008.

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SAT0467

CROSS-SECTIONAL SCREENING STUDY FOR MYCOBACTERIUM LEPRAE DNA AND ANTIBODIES IN PATIENTS UNDER IMMUNOBIOLOGICAL TREATMENT

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Background: Leprosy is an endemic disease, highly dependent of the involved proinflammatory response. Immunobiological drugs improved the treatment for autoimmune diseases, but its larger use also brought the need for screening infectious diseases. There are some case reports about leprosy and immunobiological drugs, although the real risk of leprosy in those patients is unknown.

Objectives: To access the risk of leprosy by clinical and complementary evaluation in immunobiological treated patients living in endemic region.

Methods: We conducted a cross-sectional screening study and consecutively included patients with autoimmune diseases attending Dermatology and Rheumatology ambulatory. Patients were tested for serology (anti-PGL1) and conventional polymerase chain reaction (PCR) targeting *Mycobacterium leprae* DNA.

Results: 311 patients were included: 96 on immunobiological drugs, 94 on conventional immunosuppressive drug (mostly methotrexate), 69 on non-immunosuppressive treatment, and 52 controls with no autoimmune disease or immunosuppressive treatment. Two patients of immunobiological group were diagnosed with multibacillary leprosy. The PCR for *M. leprae* was positive in more 5 subjects (1 control, 1 on MTX and 3 on immunobiologicals). The anti-PGL1 test was performed in 284 patients, and was positive in 64, 15 with a high index (above 2).

Conclusion: Immunological status is critical for leprosy control and the findings of possible subclinical infection with *M. leprae* suggest that leprosy screening should be considered in patients treated with immunosuppressive drugs.

REFERENCES

- [1] FRADE MAC, et al. Unexpectedly high leprosy seroprevalence detected using a random surveillance strategy in midwestern Brazil: A comparison of ELISA and a rapid diagnostic test. PLoS neglected tropical diseases, v. 11, n. 2, p. e0005375, 23 fev. 2017.
- [2] ANTONIO JR, et al. Biological agents: investigation into leprosy and other infectious disease before indication. An Bras Dermatol 2013; 88:23-5
- [3] LLUCH P, et al. Development of leprosy in a patient with rheumatoid arthritis during treatment with etanercept: a case report. Semin Arthritis Rheum 2012;42:127-30

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SAT0468

INFECTIOUS SPONDYLODISCITIS IN A SPANISH REGIONAL HOSPITAL BETWEEN 2000 AND 2018: 66 CASES

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Background: Spondylodiscitis have a large spectrum of clinical manifestations. The early diagnosis and treatment of this condition are essential to give the patient the best chance of a good outcome.

Objectives: To analyze the clinical characteristics, most frequent diagnostic methods and different treatments used in spondylodiscitis (SD) in our sanitary area.

Methods: Descriptive and retrospective study of patients with the diagnosis of infectious SD (clinical or microbiological) from 2000 to 2018. In each case we studied the presence of underlying diseases, an episode of infection in the previous 6 months, way of presentation, location, diagnostic methods, treatment and evolution, comparing among different etiologies.

Results: 66 patients were diagnosed of spondylodiscitis. 44 men (24-90 years: mean 71.7). 62 were pyogenic, 3 tuberculous (TBC) SD, and 1 candida. The patients with TBC were younger (mean age: 45.3; $p < 0.05$). An underlying disease was observed in 51 patients, specially Diabetes Mellitus (DM) (31% of SD). 4 patients were Rheumatoid Arthritis patients. A previous episode of bacteremia or a primary source of infection was identified in a 34.8% of the cases, obtaining a microbiological isolation in 50/66 (75.7%) SD (46 bacterial, 3 TBC and 1 Candida). The most frequent pathogens were Gram + (G+) (51% of the total SD) being *S. aureus* and *S. epidermidis* responsible of 23/66 cases (34.8%). In the 94% of SD caused by G+, hemocultures positive were obtained, in comparison to a 55% of SD caused by G- ($p = 0.016$).

The most frequent presentation symptoms were: lumbar pain (90%), fever (53%) and neurological deficit (19%). Leucocytosis was present in only a third of the SD, observing an increase of ESR and CRP in the pyogen etiology (p no significative for low number of patients in SD group caused by TBC) and lower levels of hemoglobin, cholesterol and albumin. Lumbar area was affected in the 75.7% of SD (77% in G+ and 50% in G-). In a 13.6% of patients, more than one intersomatic space was affected, being visible the presence of an abscess in 47/66 cases (71.2%). It was necessary surgical treatment in 10/47 (21.2%). 5 patients died due to pathology related to SD (7.5%), without any correlation with a risk factor and other 5 presented a relapse in the subsequent months.

Conclusion: - The bacterial SD are the predominant group, being DM the most frequent risk factor.

- The incidence of SD due to TBC and fungi is scarce in our environment, being absent the *Brucella* etiology.

- The G+ SD usually have a previous associated bacteremia.

- The majority of the patients had pain in the presentation, but only half of them had associated fever.

- The most frequent location of SD was lumbar.

- We established a 7.5% of mortality rate in our sanitary area.

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SAT0469

THE IMPACT OF CHIKUNGUNYA VIRUS INFECTION ON QUALITY OF LIFE, FUNCTIONAL STATUS AND WORK ABILITY

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Background: Chikungunya virus (CHIKV) is a reemergent arbovirus from the Alphavirus genus transmitted by Aedes species mosquitoes. The main feature of CHIKV disease is severe polyarthralgia, which is reported in more than 90% of cases. Musculoskeletal symptoms may persist in the subacute (> 3 weeks) and chronic (> 12 weeks) phases, causing critical physical impairment and significantly impacting the quality of life of patients.

Objectives: To assess the impact of CHIKV on pain, functional status, work ability and health-related quality of life (HRQoL) in the subacute and chronic phases of the disease.

Methods: Patients with a diagnosis of CHIKV disease (confirmed by PCR or serology) with persistent musculoskeletal symptoms after 4 weeks were referred to the Rheumatology outpatient clinic and followed up from April 2018 to January 2019. Evaluation questionnaires of pain (visual analogue scale – VAS), disability (Health Assessment Questionnaire – HAQ), HRQOL (Short-form 12 – SF-12) and work ability (Work Productivity and Activity Impairment-WPAI) were applied. The assessments were divided into 3 stages according to the time of disease: subacute from 4 to 12 weeks, chronic from 12 to 24 weeks and chronic with more than 24 weeks.

Results: Of the 69 patients analyzed, 76.81% were women, mean age 49.78 ± 14.24 years, 49.27% had some comorbidity (such as hypertension and diabetes), 26 were obese and 37.68% presented a previous musculoskeletal condition. Fifty-eight patients initiated follow-up in the subacute phase, in which the average pain was 6.84 ± 1.9 , mean HAQ of 1.59 ± 0.57 , mean Physical Health Composite Scale Score (PCS) of 26.81 ± 14.3 and Mental Health Composite Scale Score (MCS) of 36.77 ± 15.9 . Of the 58 patients, 35 were employed and of these, 54.25% were absent from work during the previous week. Women presented lower scores in the mental component of SF-12 ($p = 0.0215$) and the presence of comorbidity was related to higher values reported in the pain VAS ($p = 0.026$). In the chronic phase of 12-24 weeks, 50 patients were evaluated, with mean pain 5.27 ± 2.22 , HAQ 1.16 ± 0.61 , PCS of 38.82 ± 17.26 and MCS 43.72 ± 17.13 . Thirty-two patients were employed, of which 25% were absent the antecedent week. During this stage, women presented lower values of MCS ($p = 0.0245$) and the presence of obesity was related to higher values in HAQ ($p = 0.0157$). Finally, in the evaluation of the chronic phase after 24 weeks of evolution, we included 25 patients with the mean of pain 5.64 ± 2.3 , HAQ 1.11 ± 0.49 , PCS 36.72 ± 19 and MCS 41.56 ± 17.74 . Fifteen of the 25 patients were employed and 33% were absent from work the previous week. There was no significant difference between the groups evaluated after 6 months of evolution.

Conclusion: In this study, we demonstrated that the impact of chikungunya persists after 1 month of evolution in a large number of patients. The incapacity for work caused by the disease, represented by persistent rates of absenteeism at work in an economically active age group, further aggravates the magnitude of the problem.

REFERENCES

- [1] Couturier, E., Guillemin, F., Mura, et al. Impaired quality of life after chikungunya virus infection: a 2-year follow-up study. *Rheumatology*. 2012 Jul; 51(7), 1315–22.
- [2] Soumahoro, M.-K., Gérardin, P., Boëlle, P.-Y. Et al. Impact of Chikungunya Virus Infection on Health Status and Quality of Life: A Retrospective Cohort Study. *PLoS ONE*. 2009 Nov; 4(11), e7800.

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SAT0470

RISK OF HOSPITAL ADMISSION DUE TO INFECTION IN PATIENTS UNDERGOING TREATMENT WITH BIOLOGICAL THERAPY: CASE-CONTROL STUDY

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Objectives: To know risk of admission due to infection in patients treated with biological drugs (DMARDs).

Methods: Case-control study, in patients admitted for infection, treated with DMARDs, from 2000-2018. As a control group, patients included, in treatment with conventional synthetic DMARDs (DMARDcs). General data (age, gender), disease (diagnosis, time evolution, DMARDs, time in DMARDs, DMARDcs); and infection (time in DMARDs to infection, location of infection, more than one admission).

Results: Of 364 patients, 48 (13%) admitted for infection: 32 (9%) treated with DMARDs, 16 (4%) with DMARDcs alone. When comparing patients admitted vs who do not, RA predominates and no differences in the treatment with DMARDs and/or DMARDcs, corticosteroids, type of DMARD or the infection.