The first one, also had recurrent skin infections associated with bilateral anterior and posterior uveitis. The second one admitted with low-grade fever, palmoplantar erythema nodosum and positive pethargy test. The third one diagnosed as peripheral spondyloarthritis admitted with low-grade fever, palmoplantar psoriasis as well as acute extensive anterior and posterior uveitis in left eye and chronic anterior and posterior uveitis in right eye with CMV positive.

Conclusion: HIV infection might be misdiagnosed as a rheumatic disease. It is important to screen patients with inflammatory autoimmune rheumatic manifestations for HIV infection for its implications in the diagnosis and management.

REFERENCES

Disclosure of Interests: None declared

AB0899
COMPUTER TOMOGRAPHY GUIDED BIOPSY YIELD IN PYOGENIC VERTEBRAL OSTEOMYELITIS. AN EXAMINATION OF INFLUENCING FACTORS
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Background: Vertebral Osteomyelitis (VO) is an infectious disease that could involve intervertebral space (discitis), which it is avascular in adults. It is characterized by inflammation of bone cultures, which result from the spreading of a distant focus, such as infectious endocarditis or soft tissue infection. Due to the lack of direct blood supply, reliability of blood cultures is low, so biopsy is highly encouraged by current guidelines. Treatment includes long term antibiotic (ATB), that should be initiated after biopsy (if possible) and sometimes, further surgery is needed.

Objectives: To analyze which factors influence the result of a CT-guided biopsy in patients with VO.

Methods: Retrospective observational study including adult patients diagnosed of VO based on the combination of clinical presentation with either a definitive bacteriologic diagnosis or pathological and/or imaging studies, who underwent CT-guided biopsy 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. Days until biopsy from admission, prior antibiotic exposure was also collected. We considered as immuno-suppressed patients those who had rheumatic or inflammatory bowel disease and other factors which could produce neurologic complications such as paresthesia, limb weakness or even acute paraparesis (AP). One year after diagnosis.

Results: Seventy-two of 109 patients with VO underwent biopsy (66.06%). Thirty-nine brought a positive culture (54.2%). Basal demographic and clinical features are exposed in table 1. Positive cultures included 33 cases (84.61%) of Gram+ infection (23 Staphylococcus and 6 Streptococcus) and 6 (15.39%) by Gram- bacilli (3 cases of Pseudomonas aerugi-

Conclusion: In our population, it has been observed that not a single variable collected showed influence on culture result, although a negative tendency is observed in cases of prior antibiotic exposure, with no significant influence. Since CT guided biopsy is a safe technique, offering an acceptable reliability, our results support its use even in those cases that empirical antibiotic had been already initiated.

Disclosure of Interests: None declared

AB0900
ACUTE PARAPARESIS AS CLINICAL PRESENTATION OF VERTEBRAL OSTEOMYELITIS
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Background: Vertebral Osteomyelitis (VO) is an infectious disease that could produce neurologic complications such as paresthesia, limb weakness or even acute paraparesis (AP).

Objectives: To analyze the clinical characteristics of patients with VO with AP as clinical presentation.

Methods: Single center retrospective observational study including adult patients diagnosed of VO based on the combination of clinical presentation with either a definitive bacteriologic diagnosis or imaging studies, who had a clinical examination at diagnosis compatible with AP, from January 2010 to January 2019. ASIA score (American Spinal Injury Association) was registered at diagnosis and one year after. Clinical and radiological history of lumbar stenosis or disc herniation was considered as prior spine pathology. 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: In 15 of 122 patients with VO (12.80%). PA was described on physical examination at admission. Basal demographic and clinical features are exposed in table 1. ASIA scores at diagnosis and 1 year after are showed in chart 1. Duration of pain prior to diagnosis had a median of 24 days (7.5, 55). C reactive protein showed a median value of

Figure 1

ASIA scale evolution
Two Types of Systemic Amyloidosis in a Single Rheumatic Lyme Disease Symptom Based on Inflammatory Markers and Renal Function

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Background: Although amyloid fibril type varies, they usually appear in stages, but the stages can overlap. In early Lyme disease, for instance, patients have been shown to have amyloid deposition in the liver and spleen, obscuring the kidneys. Review of the bone marrow and a duodenal biopsy demonstrated amyloid deposition which was AL (lambda) type by both immunohistochemistry and proteomics. Six-cycle chemotherapy for AL amyloidosis was administered with complete clinical response. She remained on dialysis and died four years later of a cerebrovascular accident.

Conclusion: The underlying inflammatory driver of her AA amyloidosis was never identified and given that she had migrated some years earlier from Africa, previous chronic infection that has resolved or responded to non-dislosed prior treatment was thought to be the most likely cause. Whether the subsequent development of AL amyloidosis was pure chance remains unclear. Theoretically chronic inflammation/infection may drive generation of oligoclonal bands with the potential for monoclonal breakthrough. Whether her AA amyloid deposits played a role by providing a template for deposition of subsequent AL amyloidosis derived from an entirely separate precursor protein is also unknown although this theoretically possible and has been shown in reverse in mice models.

REFERENCE

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REFERENCE

Rheumatic Lyme Disease Symptoms Based on Epidemiological Data in High Endemic Europe Area

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Background: Lyme disease is a tick born infectious disease caused by different genospecies of Borrelia bacteria (B. burgdorferi sensu strictu (ss), B. afzelii and B. garinii). The signs and symptoms of Lyme disease vary, they usually appear in stages, but the stages can overlap. In early stage skin rash (erythema migrans) appears, which may be accompanied by fever, chills, fatigue, body aches, headache, neck stiffness, and swollen lymph nodes. Later signs and symptoms can be these: joint pain and inflammation, neurological problems or other less common syndromes - heart problems, eye inflammation, and liver inflammation. Lyme disease is very common disease in the world, approximately 300,000 people get Lyme disease each year in the United States (Centers for disease control and prevention US), in Lithuania disease frequency is 101.6 cases per 100 000 population (Center for Communicable Diseases and AIDS, Lithuania, 2016 year).

Objective: To investigate the frequency of rheumatic symptoms between Lyme diagnosed persons in Lithuania, based on epidemiological data.