The first one, also had recurrent skin infections associated with bilateral anterior and posterior uveitis. The second one admitted by recurrent oral and genital ulcerations associated with severe oral candidiasis, arthritis, 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.

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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. VO and discitis may occur together or independently. Both are frequently the result of a 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 immunosuppressed patients those who had rheumatic or inflammatory bowel disease undertaking immunomodulatory drugs, solid organ transplantation receptors, and 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. Spinal infections after surgery, Fungal and tuberculous disease 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: 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 aeruginosa*, 2 *Escherichia coli* and 1 *Brevundimona spp*).

	CULTURE +		CULTURE -	
	N= 39 (54.2%)		N= 33 (45.8%)	
Male sex	26	66.67%	22	66.67%
Age	62.66 (mean)	sd:15.25	61.84 (mean)	sd:11.81
High blood pressure	20	51.28%	18	54.55%
Diabetes	12	30.77%	6	18.18%
Chronic Kidney Disease III-V	7	17.95%	6	18.18%
Immunosuppressed	8	20.51%	6	18.18%
Prior Spine Pathology	22	56.41%	23	69.69%
Liver cirrhosis	5	12.82%	9	27.27%

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 significance. 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.

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AB0900

ACUTE PARAPARESIS AS CLINICAL PRESENTATION OF VERTEBRAL OSTEOMYELITIS

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Background: Vertebral Osteomyelitis (VO) is an infectious disease that could produces neurologic complications such as paresthesia, limb weakness or even acute paraparesis (AP)¹.

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 and/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.

Figure 1

Results: In 15 of 122 patients with VO (18.30%), AP 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

153mg/L (83.2, 217.57), higher results than in no AP group [85.5 (37, 144.9), $p=0.05$]. The region most frequently affected was dorsal spine (73.33%). Epidural abscess was detected in all the patients (100%) significantly higher than in no AP patients (56.07%, $p<0.01$). Similar results concerning vertebral destruction were observed (100% in AP group against 44.86% in non AP, $p<0.01$) and cord compression (93.33% versus 23.36% respectively, $p<0.01$). Eleven patients underwent CT guided biopsy (73.33%), culture positive in 33.33 of cases, with prior antibiotic exposure in five of them. Median exposure was 1.5 days (0, 4.25). In 6 patients, the picture was attributed to Gram+ (50%), in other 4 cases Gram- (33.33) and 2 cases of tuberculosis (16.67). Nine patients (60%) required further surgery and 3 patients (20%) died, slightly greater than in non AP group (10.28%) with no statistical significance, $p=0.06$.

	Acute paraparesis		No Acute Paraparesis	
	N=15		N=107	
Male sex	9	60%	73	68.22%
Age	70.2 (mean)	sd:8.36	62.03 (mean)	sd:15.28
High blood pressure	10	66.67%	56	52.34%
Diabetes	5	33.33%	22	20.56%
Chronic Kidney Disease III-V	1	6.67%	19	17.76%
Immunosuppressed	2	13.33%	16	14.95%
Prior Spine Pathology	11	73.33%	61	57.01%
Prior spine procedure	3	20%	19	17.76%
Infectious Endocarditis	1	6.67%	15	14.02%

Conclusion: Despite of being a well-known condition, VO is still an issue since 1-2 out 10 patients have a serious complication at diagnosis, such as AP. None of the basal characteristics analyzed acted as a risk factor, though AP group showed more proportion of prior spine pathology. No delay in diagnosis was noted on AP patients, but higher CRP value at diagnosis has been observed and predilection towards dorsal spine. Almost all patients tend to improve their ASIA scale, but in every case, some physical damage remain. More than a half required surgical procedure after diagnosis and mortality seems to be higher in this group.

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AB0901 TWO TYPES OF SYSTEMIC AMYLOIDOSIS IN A SINGLE PATIENT

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Background: The systemic amyloidoses are a group of rare diseases, in which extracellular deposition of a variety of proteins in an abnormal fibrillar confirmation results in life-threatening organ dysfunction. Acquired and hereditary amyloidoses differ in their precursor proteins and predilection for specific organ involvement.

Objectives: To describe the history of two types of amyloidosis developing consecutively in a single individual.

Methods: Targeted biopsies were used to confirm the presence of amyloid by Congo red staining viewed under polarized light, while immunohistochemistry and mass spectrometry were used to characterize the amyloid fibril type. I¹²⁵labeled serum amyloid P component (SAP) scintigraphy was performed to map the distribution of amyloid deposits.

Results: We report a woman of Sudanese origin who presented aged 31 with dysuria and haematuria. She was found to have an estimated Glomerular Filtration Rate of 38 ml/min and no proteinuria, and a renal biopsy demonstrated AA amyloid deposition. An I-123 labelled SAP scan demonstrated a small amount of amyloid confined to the kidneys. She had no overt underlying inflammatory disease, an infectious diseases work up, including blood borne viruses, was negative and serial measurement of serum amyloid A protein showed no significant elevation with a median of 5 mg/L. Management was blood pressure control only, and her inflammatory markers and renal function remained stable until she

was lost to follow up 3 years later. Thirteen years after her renal biopsy she represented in end stage renal failure with a history of weight loss, deranged liver function tests and marked easy bleeding. Further investigation demonstrated well controlled C reactive and serum amyloid A proteins, and an IgG lambda M-band with no serum free light chain bias. A bone marrow demonstrated 7% neoplastic plasma cells and was complicated by a retroperitoneal bleed. An SAP scan now showed a large amyloid load with 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 proteomic analysis after laser dissection and mass spectroscopy. Review of the original biopsy confirmed AA type amyloid by both immunohistochemistry and proteomics. Six-cycle chemotherapy for AL amyloidosis was administered with complete clonal response. She remained on dialysis and died four years later of a cerebrovascular accident.

Conclusion: This is the first reported case of two types of amyloidosis in a single patient. 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-disclosed 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.

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AB0902 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 stricto (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).

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