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%) significant 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 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).

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

Methods: We have analyzed data of Center for Communicable Diseases and Aids of Lithuania about Lyme diagnosed patients from 2014 to 2016 years.

Results: Total number of cases was 7425. 2791 males, 4633 females, age range 1 - 91 years, median age 52 years. 996 patients found out as symptomatic. The rest were either asymptomatic either information about clinical disease manifestation was not known. Among symptomatic patients two rheumatic symptoms were observed: arthralgia (220 cases, 22.1%), 140 females, 80 males, age range 12 - 84 years, median age 58 years, and myalgia (78 cases, 7.8%), 44 females, 34 males, age range 15-80, median age 56. Other symptoms were erythema migrans (75.6%), headache (15.2%), general weakness (12.4%), fever (10, 1%), and head dizziness (6.4%).

Conclusion: In total, almost 30 percentages (29, 91%) of symptoms were rheumatic. To conclude, joint pain and/or muscle pain can lead not only to systemic rheumatic diseases, but to infection diseases as well (for example: Lyme disease).

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AB0903

LYME ARTHRITIS IN HIGH LYME DISEASE ENDEMIC EUROPE ZONE

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Background: Lyme disease is a tick born infectious disease caused by different genospecies of *Borrelia* bacteria (*B. burgdorferi sensu strictu*, *B. afzelii* and *B. garinii*). Disease clinical manifestation varies and belongs on the variety of *Borrelia* bacteria genospecies. In America Lyme arthritis dominates, which is caused by *B. burgdorferi*, while in Europe Lyme disease is caused by *Borrelia afzelii* or *Borrelia garinii* (less commonly by *Borrelia burgdorferi*) leading to usual disease manifestation as erythema migrans or neuroborreliosis. 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 Lyme arthritis in high disease endemic European country Lithuania. To find out with joint was most frequently affected.

Methods: A retrospective, single center study was performed. We have analyzed the medical documents of adult patients, who were hospitalized to Infectious disease center (Vilnius, Lithuania), due to severe Lyme disease clinical manifestation, in 2014-2017 years.

Results: 88 patients were enrolled (57 females, 31 males, age range 18-90 years, median age 57 years). Patients were divided into four groups according disease clinical manifestation: erythema migrans, neuroborreliosis, Lyme arthritis and carditis (atrioventricular block). The most frequently erythema migrans was observed (53 cases, 62, 35 percentages (%)), than neuroborreliosis (27 cases, 31, 76 percentages), following by Lyme arthritis (3 cases, 3, 53 percentages) and Lyme carditis (2 cases, 2, 35

percentages). Between Lyme arthritis patients inflamed joints were these: knee (one case), ankle (one case) and both - knee and ankle (one case). In two cases high laboratory markers (ESR 116; 23 mm/h, CRP 125; 50 mg/l) and high body temperature (38, 2; 39, 5 0 t) was documented.

Conclusion: 2.35% of hospitalized Lyme infected patients reveal as Lyme arthritis. Inflamed joint were knee (50%) and ankle (50%). Despite the fact that it is used to think that Lyme arthritis occurs only (mostly) in America we can find it in Europe too, though its incidence is low

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AB0904

EFFECTIVENESS AND SAFETY OF RITUXIMAB IN SYSTEMIC AUTOIMMUNE DISEASES: A CASE SERIES DESCRIBING THE EXPERIENCE OF AN AUTOIMMUNE DISEASES UNIT IN A 3-YEAR PERIOD

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Background: Rituximab (RTX) is a drug composed of chimeric monoclonal antibodies against the CD20 protein, producing a depletion of B lymphocytes. Nowadays, it is used to treat severe and refractory systemic autoimmune diseases (SAD).

Objectives: Analysing the effectiveness and safety of RTX in patients with SAD in clinical practice.

Methods: We conducted a retrospective analysis of patients with SAD treated at least once with RTX in the autoimmune diseases unit of our hospital in the last 3 years. We evaluated demographic, clinical and serological variables as well as the presence of adverse events (AE).

Results: Twenty two patients have been included (13 women and 9 men, mean age 63 ±15 years). The diagnosis were ANCA-associated vasculitis (31.8%), cryoglobulinemic vasculitis (18.2%), autoimmune hemolytic anemia (13.6%), systemic lupus erythematosus (9.1%), immune thrombocytopenia in antiphospholipid syndrome (9.1%) and one each of: Felty syndrome, IgG4-related disease, necrotizing myopathy and systemic sclerosis. Indications for treatment were renal disease in 36.4% of the cases, haematological manifestations in 27.3%, skin involvement in 13.6%, neurologic manifestations in 9.1% and other different reasons in the remaining 13.6%. RTX was used after therapeutic failure with previous treatments in 81.8% and as first line treatment in only 18.1% of the cases. RTX dose was 375 mg/m² once weekly for 4 doses (54.5%) and 1000 mg on days 1 and 15 (45.5%). After rituximab, 77.3% of patients had complete response, 9.1% partial response, and 13.7% non-responding. There were 14 AE reported in 10 of the 22 patients (45.5%) (See table). Three severe infections were found: were 2 patients with invasive pulmonary aspergillosis and 1 patient with invasive cryptococcosis. All of them died within the next month after beginning RTX. One of those who were diagnosed of aspergillosis had never received steroids. The other two were treated with high dose of steroids for several months. One patient had a nonischemic cardiomyopathy (NIC) with systolic dysfunction that resolved 4 months after RTX discontinuation.

Conclusion: As far as we are concern, RTX is a useful and pretty safe biological agent in the treatment of refractory SAD. However, we must be aware of rare adverse effects such as NIC. In addition, given the potential severity of the infections found (although not totally attributable to RTX), we must closely follow up these patients for early diagnosis, treatment and even starting prophylaxis in high risk patients.