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THU0691

CLINICAL, RADIOLOGICAL, THERAPEUTIC ASPECT AND PROGNOSTIC OF INFECTIOUS SPONDYLODISCITIS WITHOUT BACTERIOLOGICAL EVIDENCE

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Background: Early microbiological diagnosis and multidisciplinary management are the main predictive factor for successful treatment in septic spondylitis. However, the therapeutic management of spondylodiscitis without bacteriological diagnosis is not well codified.

Objectives: To evaluate whether there is clinical, biological or significant imaging between patients with infectious spondylodiscitis as they had or not a microbiological diagnosis.

Methods: Retrospective study including 107 patients hospitalized in our department between 1999 and 2018. The diagnosis was based on clinical, biological, radiological and bacteriological data.

Results: This study involved 107 patients, including 58 men (54.2%) and 49 women (45.8%) with a mean age of 55 years [16–86]. Spinal pain was observed in all cases and the lumbar spine was most affected (54.2%). A neurological deficit was noted in 16.82% of cases. The inflammatory syndrome was present in 90.6% of cases. Radiographs of the spine were abnormal in 83.1% of cases. CT and Spinal MRI were performed respectively in 60% and 78.8% of cases. Disco vertebral biopsy was performed in 73 patients and was contributory in 46.5% of cases.

We divided patients into two groups: patients with a confirmed biological diagnosis (group 1: 45.3%) versus patients in whom the diagnosis had been held on presumptive criteria (group2: 54.2%). There was no statically significant difference in the age ($p=0.5$), sex ($p=0.3$), risk factors such as diabetes ($p=0.8$), the start mode ($p=0.4$), the presence of an impaired general condition ($p=0.3$), night sweats ($p=0.1$) and a neurological deficit ($p=0.8$), biological parameters ($p=0.3$) and the occurrence of complications ($p=0.09$) between the two groups. Vertebral condensation in radiographs of the spine was higher in group 2 and this was statically significant ($p=0.03$). In addition, the consumption of unpasteurized milk and positivity of wright serology was higher in the first group ($p=0.001$ and $p<0.001$; respectively). Similarly, contributive histological result of vertebral biopsy was more frequent in group 1 ($p=0.007$).

Conclusion: Diagnosing infectious spondylodiscitis is facilitated by improved access to MRI testing. However, microbiological diagnosis is the main key to a successful management of this life threatening infection.

Disclosure of Interests: : None declared

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OCULAR MANIFESTATIONS IN BEHCET'S DISEASE MAY BE MORE COMMON IN CHILDREN THAN ADULTS: RESULTS OF A SYSTEMATIC REVIEW

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Background: Behcet's disease (BD) can develop in both children and adults, but they may have different clinical features. Ocular involvement is common in BD and causes substantial impairment. The frequency of ocular involvement in BD has a wide range (5 to 89%).

Objectives: This study determined the frequency and type of ocular manifestations in childhood and adult BD and compared prevalence of ocular manifestations by geographic location in those with BD.

Methods: The protocol of ocular conditions in rheumatic conditions was registered at clintrials.gov (NCT03753893). Search terms were: conjunctivitis, keratoconjunctivitis sicca, xerophthalmia, uveitis, eye hemorrhage, optic neuritis, papilledema, orbital disease, retinal artery/vein occlusion, macular edema, retinitis, chorioretinitis, scleritis, iridocyclitis, choroid hemorrhage, blindness and amaurosis fugax in patients with BD. The search was performed with the assistance of an information specialist. Medline, Cochrane and Web of Science were used searching papers that spanned from their inception (1966, 1991 and 1990 respectively) to October 5, 2018. Studies were included if they had a minimum of twenty patients and reported the frequency of ocular manifestations within BD. Random effects models were used to combine the prevalence of ocular manifestations using Revman 5.3. Heterogeneity was evaluated using I^2 and funnel plots.

Results: The search resulted in 3129 articles, of which 33 were included for meta-analysis. Eye manifestations were more frequent in childhood onset BD with the mean [95% Confidence Interval] frequency of 50 [38–63]% compared to 34 [25–43]% in adults. In both children and adults, posterior uveitis (children 27% vs. adults 25%) was the most common ocular manifestation, followed by anterior uveitis (children 18% vs. adults 23%). When comparing the distribution of ocular manifestations in Behcet's in adults, there was geographic variation higher along the ancient Silk Road with ocular manifestations occurring in 40% of patients from Turkey and the Middle East. Ocular manifestations were similar in Europe (36%) and North America (36%), but less frequent in North Africa (26%) and East Asia (20%).

Conclusion: The frequency of ocular involvement is higher in children when compared to adults with BD. The most common manifestation in the eyes is posterior and then anterior uveitis. Ocular involvement also presents regional differences.

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Figure: The prevalence (A) and geographic distribution (B) of ocular manifestations in adults with Behcet's disease.

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INPATIENT PREVALENCE, EXPENDITURES AND COMORBIDITIES OF TAKAYASU'S ARTERITIS: A PROPENSITY-MATCHED COHORT STUDY

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Background: Takayasu's arteritis (TAK) was first described in Japan. Since then, the disease has been extensively studied in Japan and other Asian countries [1]. However, little is known about the characteristics, inpatient burden, expenditures and comorbidities of TAK in the United States (US).

Objectives: To investigate the inpatient prevalence, expenditures and comorbidities of patients with TAK in the US.

Methods: Patients with TAK were identified within the Nationwide Inpatient Sample (NIS) database of the years 2013-2014 using ICD-9 diagnostic code. NIS is a publicly available inpatient database that contained data of over 7 million hospital stays, which are a 20% stratified sample of over 4,000 non-federal acute care hospitals from more than 40 states of the US. Data on patient characteristics, comorbidities, resource utilization and expenditures was collected. A propensity-matched cohort of patients without TAK was also created from the same database to serve as comparators for the analysis of comorbidities. Inpatient prevalence of TAK was calculated using all admissions in the NIS database as denominator. Odds ratios (OR) comparing the prevalence of comorbidities between cases with TAK and propensity-matched controls without TAK were calculated.

Results: A total of 2,840 patients with TAK were identified from the database, corresponding to an inpatient prevalence of 4.6 cases per 100,000 admissions. The 5 main reasons for admission in patients with TAK were as follows; chest pain (17%), acute myocardial infarction (16%), stroke (14%), sepsis (14%) and pneumonia (11%). Compared to the propensity-matched cohort of patients without TAK, patients with TAK were found to have significantly increased odds of stroke, aortic aneurysm, aortic valvulopathy and peripheral vascular disease. TAK was also associated with increased use of some procedures (Table 1). However, the mortality was not significantly different (adjusted OR: 1.44, 95% CI: 0.58 – 3.61, p=0.43). After adjusting for confounders, patients with TAK displayed a mean additional \$11,275 (95% CI, \$4,946 - \$17,603) for total hospital costs (the amount of money invested by each institution in providing patient care) and a mean additional \$45,305 (95% CI, \$23,063 – \$67,546) for total hospitalization charges (the amount of money that each hospital billed for providing its service on each case) when compared to patients without TAK.

Conclusion: The inpatient prevalence of TAK was higher than what would be expected from the overall incidence. The mean total hospital costs and total hospitalization charges for patients with TAK were higher than patients without TAK. Analysis of comorbidities found significantly higher odds of several vascular comorbidities compared to a propensity-matched cohort of patients without TAK.

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Table 1. Adjusted ORs comparing the prevalence of comorbidities and use of procedures between patients with TAK versus patients without TAK

	Adjusted odds ratio	95% CI	p-value
Comorbidities			
Stroke	4.66	2.10-10.31	<0.01
Aortic aneurysm	40.76	9.13-181.7	<0.01
Peripheral vascular disease	2.01	1.22-3.32	<0.01
Acute myocardial infarction	2.13	0.56-8.13	0.27
Aortic valvulopathy	4.92	2.09-11.55	<0.01
Chronic kidney disease	1.22	0.63-2.63	0.57
Procedures			
Aortic valve replacement	1.39	0.42-4.60	0.59
Peripheral vascular intervention	4.41	1.61-12.10	<0.01
Arteriography	6.82	2.79-16.68	<0.01
MRI use	2.60	0.42-16.28	0.31

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BRAZILIAN SJÖGREN'S SYNDROME REGISTRY (BRASS): A LARGE BRAZILIAN MULTICENTRIC COHORT OF PRIMARY SJÖGREN'S SYNDROME

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Background: Primary Sjögren's syndrome (pSS) is an orphan systemic autoimmune disease with no treatment based on evidence¹. There is an international effort for multicentric registries for getting information about phenotypes, complication, response of treatment, and biobank consortium.

Objectives: To describe the creation of the Brazilian Sjögren's Syndrome Registry (BRASS) and present the preliminary data.

Methods: BRASS is supported by Brazilian Society of Rheumatology (SBR) and is including patients from all regions of the country. Recruitment started in 2018 and is due to be completed in 2024. We are including patients with pSS according to AECG 2002 or ACR-EULAR 2016 classification criteria. All patients are being assessed for disease activity (ESSDAI), disease damage (SSDDI), symptoms assessment (ESSPRI), fatigue (FACIT-Fatigue), anxiety and depression (HADS), sleepiness (Epworth Sleepiness Scale), physical activity (IPAQ-SF) and quality of life (EQ-5D). In addition, demographics, immunological tests, unstimulated whole salivary flow (UWSF), salivary gland biopsy (SGB), comorbidities, treatment and complications such as cancer and cardiovascular risk assessment are being collected.

Results: There are currently 10 centers across the Brazil and 248 patients were evaluated until now. Most patients were female, white (45%) or mixed (38.3%), with the mean of the disease duration of 8 years. ESSDAI at baseline was 6.62±6.37 and currently is 4.21±5.16 (p<0.05). The mean of the SSDDI was 2.16±1.60 and ESSPRI 8.38±6.88. SGB was positive in 81.5% and focus score mean was 1.58±1.30. Schirmer test I was positive in 72.6%, van Bijsterveld in 70.9% and UWSF in 84.8%. About classification criteria, 91.9% fulfilled AECG 2002 and 94% ACR/EULAR 2016. Anti-Ro and anti-La were positive in 70.8% and 35.5%, respectively. Forty three percent had positive RF, 88.5% ANA, 6.9% low C3, 10.2% low C4, 34.9% high IgG. Nineteen percent were using prednisone, 40.4% immunosuppressant, 53.6% antimalarial and 17.6% biological therapy. Prevalence of cardiovascular event was 7.5%, hypertension 43.3%, diabetes 13.3%, dyslipidemia 31.5%, smoking 5.8% and cancer 7.5%.

Conclusion: ESSDAI has decreased over time and more than half of patients are on hydroxychloroquine, immunosuppressant or biological therapy. Further analysis is needed to understand whether the reduction in ESSDAI reflects the natural course of the disease or greater access to