AB0918 REACTIVE ARTHRITIS POST VIRAL – AN UNUSUAL PRESENTATION IN AN EPIDEMIC IN NORTH INDIA

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Background: This study was performed at a Private hospital in New Delhi, India during the epidemic phase of Viral fever. The peak months of viral fever from mosquitoes (Aedes Aeygpti) like Dengue and Malaria (Anopheles)has been from July to October, till the holy festival of Diwali arrives. Chikungunya came like a wave this time along with dengue and Malaria.The worst epidemic since the last 6 years.A disease common in South India, took North India by a storm. 15–20 deaths were also reported due to Chikungunya virus. Apart from Chikungunya (serology negative) there were a lot of other viruses causing arthritis. Our study deals with post viral arthritis, a new variant which has never been described before.
Objectives: 1. To study the pattern of arthritis after viral fever. Is it reactive or a new variant
2. To observe for the evolution of Acute viral arthritis into chronic arthritis
3. The management of Post viral arthritis
Methods: It is a retrospective study conducted at the end of the epidemic. The patients are being followed up over next 3 months to observe for resolution of symptoms, persistent arthritis or evolution into chronic form. 100 patients are being included which were examined and independently assessed by 3 different consultants.
Inclusion criteria: 1. All patients who presented with complaints of persistent joint pains and swelling preceded by fever (Average duration 4–8 weeks). 2. Documented synovitis (Oligoarticular and polyarticular)
Exclusion criteria: 1. Known case of Rheumatoid Arthritis, Connective tissue disease, Vasculitis and Spondyloarthopathy 2. Arthalgia with no documented synovitis 3. Patients on DMARDS previously
Results: Detailed results are still under compilation as patients are under follow up (6 months) for further course.
No of patients: 100
Average Age: 47
Average Disease Duration: 6 weeks (after fever)
Average No of Joints involved: 3–4
Symmetry: All Asymmetrical (Large+ Small)
80% patients had asymmetrical joint involvement. Most common joints were: MCP followed by PIP and then the large joints: shoulders and ankles. It was associated with significant early morning stiffness (30 minutes) like other inflammatory arthritis. 60% had response to short course of NSAIDS and low dose steroids (Injection Depomedrol 80 mg intramuscular once a week) and recovered in 2 weeks, 30% had a prolonged course of 4–6 weeks, butdid not need any further medications. 5% developed into Chronic arthritis (Further follow up pending)
Conclusions: Reactive arthritis is a known entity and it has typical involvement of the lower limbs, usually preceded by urinary tract infection or GI infection. Even with Viral arthritis, the presentation of joint pains and swelling is usually during the acute fever episode. The pattern described here was different. All the patients had fever at presentation which lasted for 3–5 days and 4–6 weeks later they developed synovitis. There was characteristic involvement of Small joints of the hands (PIP and MCPS) (different from reactive).We are still in process of collecting follow up data which will give us a clue on prognosis of this arthritis and future prospects. So, what do we label it as ... Reactive arthritis-a new variant or a post viral arthritis.
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Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.1168

AB0919 THE PROGNOSTIC FACTORS DURING OSTEOARTICULAR TUBERCULOSIS

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Background: Osteoarticular tuberculosis (OAT) is still common in Mediterranean countries such as Tunisia.The incidence of OAT is increasing, mainly related to expanding immunosuppressive factors and comorbidities.
Objectives: This study aimed to analyze the prognostic factors and therapeutic outcomes of OAT.
Methods: Over a period of 20 years [1996- 2016], patients with the diagnosis of OAT were retrospectively identified. Clinical, laboratory and radiology features in these patients were analyzed to identify the prognostic factors.
Results: Sixty patients (29 men) fulfilled the diagnostic criteria, admitted to the Rheumatology Service with an average of 54 years (range: 16 to 86).We did not find any significant association between prognosis and an advanced age (>60years) at the time of diagnosis, a long diagnostic delay or initial neurologic involvement.However, we found that cervical localization in tuberculous spondylodiscitis, classified as an only infection site or in multi-level vertebral damage, was significantly associated to a poor prognosis.Our study revealed that hyperleucocytosis higher than 11500 elements/mm^3 at the initial blood count constituted the only biological bad prognostic factor during OAT. Based on radiological findings, the presence of abscess or vertebral compression fractures on bone imaging (MRI)and the presence of vertebral deformity (kyphosis or kyphoscoliosis) were strongly linked to a bad outcome.The following table (Table1) summarizes the poor prognostic factors during OAT.

Table 1. The poor prognostic factors during OAT

PROGNOSTIC FACTOR	p	Odds Ratio
White blood cell counts >11500 elements/mm^3	0,041	22
Presence of abscess on MRI	0,024	13
Presence of vertebral compression fractures	0,018	Indefinite
Vertebral deformity	<0,001	Indefinite
Cervical localization	0,033	15
Age>60years	0,078	–
Long diagnostic delay	0,062	–
Initial neurologic damage	0,053	–

Conclusions: This study revealed that cervical localization in tuberculous spondylodiscitis, initial hyperleucocytosis, and the presence of abscess on MRI as well as vertebral compression fractures and vertebral deformity are associated with a bad outcome in OAT.
Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.2997

AB0920 TUBERCULOSIS OSTEOMYELITIS OF THE PUBIC SYMPHYSIS: REPORT OF TWO CASES

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Background: Infection of the symphysis pubis is a rare complication for less than 1% of cases of osteomyelitis. The predisposing causes reported are pelvic surgery, trauma and intravenous drug abuse. We report cases of osteomyelitis of the pubic symphysisdue to mycobacterium tuberculosis which is extremely
Results: The two patients were 47 and 75 year-old women. They were admitted because of three month's history of progressive perineal pain and a hypogastric mass without fever in the first case, and bilateral inguinal pain with limited flexion and rotation of the right hip in the second one. Blood tests showed an elevated erythrocyte sedimentation rate (ESR) of 27 mm and 75 mm. The leucocytes rates were at 5580/mm^3 and 6000/mm^3. Plain X-ray revealed irregularity and widening of the symphysis pubis. Tuberculin skin test was positivein one case and negative in the other. Chest radiograph was normal. The bacteriological cultures for tubercule bacillus in sputum and urines negative. The typhic and brucellian serological diagnosis as well as blood cultures were negative. CT scan showed irregular destruction and erosion of the pubic bone with a soft tissue mass. A biopsy of the symphysis was performed. Histologic examination of the bone material revealed a granulomatous inflammation with caseous necrosis confirming the diagnosis of tuberculosis. Anti-tuberculous treatment was prescribed and led to full recovery.
Conclusions: Tuberculosis is a major health problem in mediterranean countries,including Tunisia. These two cases present a timely reminder that tuberculosis should always be considered as part of the differential diagnosis of treatment of tuberculosis osteomyelitis of the pubic symphysis. Radiological investigations with plain X-rays, CT, MRI and bone scan are hepful. Treatment of tuberculous osteomyelitis of the pubic symphysis is based mainly on anti-tuberculous drugs.
Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.6940

AB0921 INFECTIOUS SPONDYLODISCITIS: EPIDEMIOLOGICAL, CLINICAL, PARACLINICAL AND THERAPEUTIC ASPECTS

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Background: Spondylodiscitis is an infection of a disc and the two adjacent vertebrae due to the introduction of a pyogenic, usually by the haematogenous route. It's quite a rare disease accounting for 2–7% of all cases of septic osteomyelitis [1, 2].
Objectives: To study the clinical, microbiological, radiological, therapeutic and evolving of infectious spondylodiscitis
Methods: A retrospective descriptive study conducted over years in the department of rheumatology, including all patients with infectious spondylodiscitis. Clinical given were collected from paper patients records.
Results: We included 67 patients. There were 38 men and 29women. The mean age was 55 years. The male to female ratio was 38:29.Risk factors of spondylodiscitis were observed in 19 patients. The approximate time from onset of symptoms to diagnosis was from 3 to 365 days (median, 132 days). Back pain was the most common symptom. Spinal syndrome was found in all patients. The most frequent location of spondylodiscitis was lumbar spine. Signs of spinal cord compression including paraplegia or paraparesis of the lower limbs were observed in 31 patients. Pachymeningitis was associated in 1

case. The paravertebral abscess was associated to the disc involvement in 23 cases. Epiduritis was associated in 21 cases. Plain radiography, performed in in the majority of cases (63 cases, 94%), demonstrated pathological pictures in 56 (83.5%) patients. MRI, performed in 60 (89.5%) patients, disease was in all patients. Pathogens were isolated in 43 (64.1%) cases. Tuberculosis was the most common cause. The leading causative agents in non tuberculousspondylodiscitis were: Staphylococcus aureus (8 isolates, 11.9%), brucella (7 isolates, 10.4%), Escherichia coli (2 isolates, 2.9%) and streptococcus B (1 isolates, 1.4%).Two microorganisms combined (mycobacterium tuberculosis and a pyogenic) was found in one case. Medical treatment was adapted to the prescribed seed. Surgical treatment was performed in 6 patients. After therapy, 59 (88%) patients had regression of symptoms, two patients had a permanent neurological impairment (paraplegia), one patient had recurrence of infection and one patient was dead.

Conclusions: Infectious spondylodiscitis has been diagnosed with increasing frequency. It should be taken into consideration in differential diagnosis in patients with significant back pain and laboratory evidence of an acute inflammatory process, especially metastatic spinal disease or inflammatory spondyloarthritis

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.6916

AB0922 CLINICAL MANIFESTATIONS AND OUTCOMES OF ACUTE SEPTIC ARTHRITIS IN SONGKLANAGARIND HOSPITAL: A 10-YEAR RETROSPECTIVE STUDY

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Background: Septic arthritis is a rheumatologic emergency. Its delayed diagnosis and treatment cause joint morbidity and mortality.[1] Cases involving antimicrobial-resistant bacteria have been reported.[2,3]

Objectives: To determine the clinical manifestations and outcomes of septic arthritis, find the factors associated with mortality, and discover the incidence of drug-resistant organisms in our institution

Methods: A retrospective study was performed. Septic arthritis was defined as the presence of acute inflammatory arthritis indicated by a positive synovial fluid or synovial tissue culture for bacteria. A total of 116 septic arthritis patients, who visited Songklanagarind Hospital from January 2005 to December 2014, were reviewed.

Results: The patient median age was 58 (IQR: 46, 72). Sixty-one patients (52%) were female. The median onset of symptoms and symptoms until diagnosis were 5 (IQR: 2, 7) and 6 (IQR: 3, 10) days, respectively. Eighty-eight cases (76.7%) had underlying diseases that might predispose to joint infection. Sixty-nine cases (59.5%) had pre-existing joint disease. Joint pain was the most common presenting symptom, and 58% of the cases had fever. The most common presentation was monoarthritis (87%), which was predominantly associated (78%) with knee joint involvement. The median synovial fluid leukocyte counts were 64,460 cells/μL (IQR: 30,300; 129,000). Blood cultures were positive in 53 patients (49.1%). Synovial fluid cultures commonly had *Streptococcus spp.* growth (41%). Seven cases (7%) involved drug-resistant organisms. All of them either were diagnosed with septic arthritis during hospitalization or had a history of previous surgery. Twenty-five percent of the cases obtained the empirical antibiotic, ceftriaxone, and 86 patients (80%) underwent arthrotomy drainage. The mortality rate was 12%, and its associated factors were cancer, liver disease and advanced age.

Conclusions: *Streptococcus spp.* is an emerging cause of septic arthritis in Southern Thai patients. Physicians should be aware of this in patients presenting with fever and acute monoarthritis, particularly those with comorbidities and underlying joint diseases. The proper empirical antibiotic of choice is ceftriaxone.

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.1737

Fibromyalgia

AB0923 MEETING THE FIBROMYALGIA CRITERIA HAS A NEGATIVE IMPACT ON TNF INHIBITORS EFFICACY IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS

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Background: Fibromyalgia and spondyloarthritis can coexist and the overlap between the two diseases could have consequences on TNF inhibitors efficacy.

Objectives: To evaluate TNF inhibitors efficacy in patients with axial spondyloarthritis fullfilling or not fibromyalgia criteria.

Methods: Prospective observational bicentric study on 25 patients who met ASAS 2009 axial spondyloarthritis criteria. Fibromyalgia was defined by ACR 2010 fibromyalgia criteria or by a ≥5/6 score of the Fibromyalgia Rapid Screening Tool. Following items were recorded before and after a 6 months treatment with TNF inhibitors: Visual Analog Scale for pain and for patient global disease activity, values of ESR and CRP, number of tender joints, MASES score, number of Yunus tender points. All patients filled a self-questionnaire with BASDAI, BASFI, FiRST and ACR 2010 fibromyalgia scale items using SSS and WPI. Criterion of judgment: an ASAS partial remission state was compared in patients with or without fibromyalgia.

Results: Of the 25 patients enrolled, 15 (60%) fulfilled ACR 2010 fibromyalgia criteria and 9 (36%) had a ≥5/6 FiRST score. The proportion of patients fulfilling an ASAS partial remission state was significantly lower in patients with fibromyalgia according to the ACR 2010 criteria (20% vs 70%, p=0,034) or to the FiRST score (0% vs 62,5%, p=0,0028). These patients had more severe disease activity and physical fonction than the patients without fibromyalgia. In this study, some factors were related with absence of ASAS partial remission: female gender, prior TNF inhibitor failure, ACR 2010 fibromyalgia criteria positivity, to have more than 11 Yunus points and to have a ≥5/6 FiRST score.

Conclusions: Meeting the fibromyalgia criteria might have an impact on ASAS partial remission state and on efficacy of TNF inhibitors in patients with axial spondyloarthritis. The FiRST score was more specific to predict an absence of ASAS partial remission than the ACR 2010 fibromyalgia criteria. TNF inhibitors should be used with circumspection in case of FiRST score ≥5/6 in patients with axial spondyloarthritis.

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.4310

AB0924 THE ROLE OF SELF LIMITING BEHAVIOUR, DEPRESSION AND SLEEP IN THE SEVERITY OF FATIGUE IN PATIENTS WITH FIBROMYALGIA

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Background: Fatigue and sleep disturbances are prominent symptoms in Fibromyalgia (FM) and significantly affect the level of the patients' impairment. Some studies reported a synergic interaction of depression and poor sleep quality associated with fatigue (e.g. [1]); while Marques et al. [2] showed a significant association of the fatigue severity with a limiting behaviour self-regulatory style of the patients, i.e. reducing daily activities and excessive resting.

Objectives: The purpose of this cross-sectional study was to analyse the predictors of severity of fatigue in Italian patients with FM.

Methods: Outpatients with a FM diagnosis who fulfilled both ACR/EULAR 1990 and 2010 criteria [3,4], after a medical visit at the Fibromyalgia center at Sapienza University Hospital "Umberto I", were invited to participate in a study on their cognitions and behaviours wearing for one week a wrist actigraph (AMI Motionlogger Watch). Actigraphic sleep parameters were averaged over six days. After 7 days the participants returned the actigraph and answered a structured interview conducted by a trained psychologist which included validated scales measuring depression (Brief Symptom Inventory [5]), perceived fatigue (Checklist of Individual Strength [6]), sleep habits (Sleep Disorder Questionnaire [7]) and behaviour regulation patterns (All-or-nothing and Limiting behaviour scales from Behavioural Responses to Illness Questionnaire [8]). In the previous month and during the study, pharmacological and non-pharmacological treatments were unchanged.

Results: Actigraphic monitoring and structured interview were completed by 39 female FM patients, with a mean age of 44.9 years (SD=8.55) and an illness mean duration of 6.5 years (SD=5.72). The majority of the patients reported insomnia complaints, and 29 (74.4%) met the DSM criteria for chronic insomnia. Fatigue severity resulted as the best subjective measure of fatigue, and was positively and significantly correlated with self-management through limiting behaviour, and with Total Time in Bed (TTB) measured through actigraphy. The correlation between TTB and Total Time Slept (TTS) and depression were not significant. Hierarchical regression considering TTB, Depression and Limiting behaviour, showed that all these variables give a significant independent contribution to the prediction