Methods: A retrospective study including all patients suffering from CHC followed over a period of 11 years (2002–2012). Were excluded all patients co-infected by hepatitis B virus or by human immunodeficiency virus and those having decompensated cirrhosis. Different RM were collected and analysed according to the epidemiological, clinico-biological, immunological, virological and histological data of the CHC.

Results: Two hundred and four patients affected by CHC were included, mainly aged by 52 years [22–66 years]. The sex-ratio was 0.46. MR were noted in 76 patients (37.25%) dominated by inflammatory polyarthralgia of big joints (88.25%). Non erosive arthritis was observed in a woman and was localised to the proximal interphalangeal articulation of the index. Myalgia were noted in 11 cases (14.47%) among them, 2 appeared under antiviral treatment. Sicca Syndrome was observed in 17 cases (22.36%). RM were associated to other extrahepatic manifestations of CHC in 69.7% of cases, notably to mixed cryoglobulinemia (MC) (60%) and to antinuclear antibodies (21.6%). Anti DNA, anti SSA, anti SSB, rheumatoid factor and anti CCP were absent in all cases. A partial to total amelioration of RM was noted in almost patients under antiviral treatment and sometimes associated to symptomatic measures. In univariate analyse, only female sexe and presence of MC were significantly correlated to the presence of MR.

Conclusions: During CHC, MR are frequent, dominated by arthralgia, myalgia and sicca syndrome. Authentic arthritis are rare and constitute a diagnostic problem essentially when they inaugurate the disease. MC is the immunological factor the most associated with RM. Treatment of MR still antiviral.

Disclosure of Interest: None declared

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AB1050 REACTIVE ARTHRITIS DUE TO PARVOVIRUS B19 MAY BE OVERLOOKED IN ADULT RHEUMATOLOGY

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Background: In 1991 parvovirus B19 analyses, for the 5th disease of childhood, were established in Denmark, revealing the first epidemic. Prior to this, erythema infectiosum, "slapped cheek appearance" and reactive arthritis were only clinical diagnoses. A project in the PhD thesis Human Parvovirus B19 Erythrovirus – Methods established for Virological and Diagnostic Aspects 2006 APMIS 120;114:1–121, revealed that 35.4% of 3.628 pregnant women were susceptible to parvovirus B19 infection.

Objectives: To present manifestations of parvovirus B19 in a susceptible adult population

Methods: During the years 2011–2014 and 2017 the following patients were admitted.

Case 1: A 61-year-old woman with rash and thrombocytopenic purpura in April 2011. Routine blood tests, RF, anti-CCP, tuberculosis, ANA and anti-ds DNA, serological tests for viral and autoimmune hepatitis were performed. Also ECG and finally, parvovirus B19 IgM and IgG, PCR for Parvovirus B19 was performed, June 2011

Case 2: A 52-year-old woman with rash, swollen joints and pericarditis in May 2011

Case 3: A 45-year-old woman with swollen joints, March 2011

Case 4: A 45-year-old woman with swollen joints and rash, November 2014

Case 5: A 68-year-old man admitted to the Department of Dermatology and diagnosed with Sweet's Syndrome, severe anaemia and swollen joints, September 2014

Case 6: A 62-year-old woman transferred due to parvovirus B19 positive IgM and IgG antibodies with reactive arthritis and itching skin rash, June 2017

All six patients were tested as mentioned above in Case 1.

Results: In all 6 patients, routine tests were normal. HBV, STD, ANA, anti-dsDNA, TB, RF and anti-CCP were negative. Parvovirus DNA by PCR, IgM and IgG antibodies were positive except for the last patient, who did not have PCR but a punch biopsy of her maculo-papular rash performed. Ultrasound revealed oedema and synovitis in the patients.

The 1st patient contracted parvovirus B19 from her 4-year-old grandchild, the 2nd during work in a daycare. They both had self-limiting infections and pericarditis resolved without treatment. The 3rd patient was also infected from daycare and her persistent synovitis, required DMARDs and biologic treatment.

The 4th patient was treated with DMARDs for one year. The 5th patient had severe anaemia for ½ year, almost overlooked due to Sweet's syndrome but his anaemia (due to replication of the parvovirus in erythroblasts) was finally diagnosed. The patient continues treatment for Sweet's Syndrome at the Department of Dermatology.

The 6th patient slowly recovered from her skin rash and reactive arthritis.

Conclusions: The 5th disease of childhood was almost overlooked in 6 patients probably due to their ages. Therefore, clinicians must be aware of the need for parvovirus B19 analyses in seronegative RA patients. Parvovirus B19 occurs as epidemics approximately every 3rd year as an occupational risk, jeopardising

patients' female family members who may be pregnant and develop foetal hydrops and anaemia necessitating intrauterine blood transfusion at a Foetal Medical Centre.

Disclosure of Interest: None declared

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AB1051 BRUCELLOSIS IN RHEUMATOLOGY: A STUDY OF 27 CASES IN TUNISIA

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Background: Brucellosis is an endemic zoonosis in the Mediterranean basin. The osteo articular localization, although rare, remains redoubtable.

Objectives: The aim of our work is to study the characteristics of osteoarticular brucellosis in Tunisia.

Methods: This is a descriptive retrospective study including 27 cases of osteoarticular brucellosis, collected in a rheumatology department over a period of 12 years (2006–2017)

Results: The Sex Ratio Female/male was 1.07 with an average age of 50.9 years.^{15–76} Diagnosis delay was 5.9 months [0.3–13]. The diagnosis of spondylodiscitis was retained in 23 patients (85.2%) and sacroiliitis in 4 cases (14.8%). Spinal or sacroiliac pain was found in all patients. Fever was present in 22 patients, sweat in 11 patients, loss of weight or appetite were respectively found in 16 and 12 patients. Eleven patient reported fatigue.

Laboratory examination found high erythrocyte sedimentation rate in 23 patients with an average of 69.4 mm.^{10–120} CRP was elevated in 26 patients with an average of 59.6 mg/L [3.3–237], the WBC average was 9451 elements/ml [5550–14 000]. Wright serology was positive in all cases, Rose Bengal was positive in 15 cases, and IFI was positive in 3 cases. *Brucella melitensis* was isolated in blood cultures in 3 cases.

Standard X Rays showed disk involvement in 21 patients, vertebral lesions in 20 cases and sacroiliitis in 4 patients. Sectional imaging (MRI or CT) was performed for all patients confirming standard X rays data and showing abscess in 13 patients and epiduritis in 7 patients.

The most affected spinal segment was the lumbar one (13 cases), cervical localization was found in 5 cases and thoracic in only 1 case. The spondylitis was multifocal in 2 cases.

Spinal disc biopsy was performed in only 4 cases, neither anatomopathologic nor bacteriological examination were conclusive.

The treatment was based on the cycline and rifampicin combination for an average duration of 4.5 months.^{3–9}

The evolution was favourable in the majority of the cases with a relapse in only 2 cases.

Conclusions: Osteoarticular brucellosis is a focal form of brucellosis, the most frequent location is spinal and whose adequate treatment allows a favourable evolution.

Disclosure of Interest: None declared

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AB1052 COMPARISON OF SEVERAL BIOMARKERS (MMP-2, MMP-9 AND ITS INHIBITOR TIMP-1, CTX-II, CALPROTECTIN AND COMP) IN THE SYNOVIAL FLUID AND SERUM OF PATIENTS WITH AND WITHOUT SEPTIC ARTHRITIS

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Background: Diagnosing septic arthritis (SA) is an emergency, and for a diagnosis to be made a microorganism must be found in the synovial fluid or blood culture. Besides direct bacteriological examination, which is positive in only 25% to 50% of cases, no laboratory examination can differentiate SA from other forms of arthritis.

Objectives: To assessed the performances of several serum and synovial biomarkers (matrix metalloproteinase [MMP]–2, MMP-9, the metalloproteinase inhibitor [TIMP]–1, cartilage oligomeric matrix protein [COMP], C-terminal telopeptide of type II collagen [CTX-II], and calprotectin [CALP]) for discriminating between septic and non-SA in a population of patients with suspected SA.

Methods: Using the ELISA technique, a number of potential biomarkers (MMP-2, MMP-9, TIMP-1, COMP, CTX-II, and CALP) were measured in the synovial fluid and serum of 39 patients with suspected SA (of whom 21 had SA and 18 non-SA). The levels of the various markers were compared on univariate and then multivariate analysis using logistic regression.

Results: The two groups were similar in terms of age, gender, history of diabetes and type of joint affected. SA patients had higher whole blood white blood cell counts ($p=0.03$) but similar C-reactive protein levels. Synovial fluid was more frequently turbid in septic cases than in non-septic ones.

Serum TIMP-1 ($p=0.003$), synovial MMP-9 ($p=0.002$), serum ($p=0.03$) and synovial CTX-II ($p=0.004$), and serum ($p=0.04$) and synovial CALP ($p=0.03$) were significantly higher in the septic group than in the non-septic group. The AUCs for diagnosing SA of synovial MMP-9, serum TIMP-1, synovial CTX-II, and serum and synovial CALP were, respectively, 0.84, 0.79, 0.81, 0.7 and 0.72.

A combination of serum TIMP-1 and synovial CTX-II led to 75% sensitivity and 94% specificity for diagnosing SA (AUC 0.89) and correctly classified patients in 86% of cases.

Serum TIMP-1 and synovial CTX-II did not correlate with each other ($r=0.1$) and did not correlate with C-reactive protein ($r=0.4$ and $r=0.25$, respectively) or synovial white blood count ($r=-0.04$ and $r=0.27$, respectively).

Conclusions: The combination of two laboratory measurements, serum TIMP-1 and synovial CTX-II, may make it possible to differentiate SA from other forms of arthritis in 86% of cases. These results need to be confirmed in larger samples of patients.

Disclosure of Interest: None declared

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AB1053

ADVERSE EFFECTS AND THEIR CONSEQUENCES IN PATIENTS WITH CHRONIC INFLAMMATORY ARTHROPATHIES IN TREATMENT WITH BIOLOGICAL THERAPY

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Background: The introduction of biological therapies (BT) for the treatment of chronic inflammatory arthropathies (CIA) has improved the prognosis of these diseases and the quality of life of patients. However, the safety of these drugs in the long term continues to be an aspect of interest.

Objectives: This study aims to review the safety of BT in patients with CIA and the consequences of these adverse effects for patients and the health system under daily clinical practice conditions.

Methods: A descriptive, observational and retrospective study was performed. All patients with CIA: rheumatoid arthritis (RA), ankylosing spondylitis (AS) and psoriatic arthritis (PsA) who started BT (abatacept, adalimumab, certolizumab, etanercept, golimumab, infliximab, tocilizumab and ustekinumab) from January 2009 to January 2017 in the Rheumatology Department of the Sanitary Area of Vigo (Spain) were included. Demographic variables (age, sex), variables related to CIA and their comorbidities: clinical and analytical data (CRP, ESR, haemoglobin, DAS and BASDAI) and years of disease evolution and variables about BT: concomitant treatment (glucocorticoids, methotrexate and leflunomide), persistence, adherence and number of lines were collected. Variables about the adverse effects (AEs) of BT: type and clinical consequence, requirement for additional visits to the Rheumatology clinic, visits to the Emergency Department or need for hospital admission was also collected.

Results: Three hundred sixty-two patients and 478 BT lines (250 lines in patients with RA, 119 with AS and 109 with PsA) were analysed (mean $\pm$ SD of BT lines: 1.7 ± 1.1 per patient). In 301 (63.0%) BT lines, some AEs occurred. In total, 683 AEs were detected (0.57 AEs per patient and year of treatment). The most frequent types of AEs were: bacterial infection (0.39 events per year of BT), viral infections (0.04 events per year of BT), fungal infections (0.04 events per year of BT), reactions related to the administration of BT (0.03 events per year of BT) and cardiovascular alterations (0.02 events per year of BT). Certolizumab and abatacept were the drugs that were more associated with bacterial infections: 0.82 and 0.69 per year of BT, respectively. Infliximab was the BT that was less associated with bacterial infections: 0.24 per year of BT. There were 7 deaths in probable relation with the AEs (4 bacterial infections, 1 cardiovascular event and 2 solid tumours). The AEs caused 71 hospital admissions (668 days of hospital stay), 113 hospital emergency room visits and 42 urgent visits to the Rheumatology Department. Sixty percent of the AE were managed from Primary Care without having to go to the hospital. The AEs caused a definitive interruption of BT in 51 episodes and a switch to a different BT in 52 episodes.

Conclusions: In our setting, patients with CIA on BT have an incidence of 0.57 AE per patient and year of BT. Infection (particularly bacterial) is the most frequent AE. Although more than 50% of these AEs are managed from Primary Care, they imply a high consumption of hospital resources.

Disclosure of Interest: None declared

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AB1054

FACTORS ASSOCIATED WITH TUBERCULOSIS IN RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) is associated with infections that are favoured by the disease itself or by its treatments. Tuberculosis (TB) is a severe infection that can occur in patients with RA, especially with the use of anti TNF.

Objectives: We aimed to estimate the incidence of TB in RA patients and identify factors associated with TB during RA.

Methods: This is a retrospective study of RA patients according to ACR/^{EULAR} criteria 2010 collected in rheumatology department during the period from April 2010 to April 2015. Diagnosis of latent or patent TB was made as part of the pretreatment screening (biotherapy) or if signs of infection occurred.

Results: During the study period, 150 RA patients (124 women and 26 men) were enrolled. The mean age was 57.09 years.²⁵⁻⁸⁵ Mean disease duration was 7.52 years.¹⁻²⁶ Rheumatoid Factor was positive in 79% of cases. Eighty eight per cent of patients received corticosteroids with a mean dose of 10 mg/day.⁵⁻²⁰ All patients were treated with at least one conventional synthetic disease-modifying antirheumatic drug (methotrexate, sulfasalazine and leflunomide in respectively 87%, 37% and 7% cases) and only 36 (24%) patients received biotherapy. A history of patent TB treated appropriately and prior to RA, was found in 5 patients (3%): 3 pulmonary TB and 2 lymph node forms. The pretreatment test showed 11 cases of latent TB (30%). No relapsed TB was reported on RA treatment. Nine cases (25%) of new active TB were noted during biotherapy: 5 pulmonary TB (under infliximab, adalimumab and tocilizumab), 2 lymph nodes TB (under infliximab) and 2 urogenital TB (under infliximab). In our study, factors associated to TB infection were an advanced age, high level of C-reactive protein, a history of diabetes, dose of steroids ≥ 7.5 mg/day and dose of Infliximab > 3 mg/kg (table 1).

Abstract AB1054 – Table 1. Factors associated to TB in RA patients

Factors	Odds ratio	P
Age	1.7	0.02
Sex: male/female	0.3	0.5
Diabetes	1.6	0.04
Erythrocyte sedimentation rate (mm)	0.6	0.7
C reactive protein(mg/l)	1.5	0.03
RA duration	0.95	0.31
Corticosteroid duration	0.9	0.45
Dose of steroid ≥ 7.5 mg/day	1.1	0.01
Dose of methotrexate	0.5	0.64
Dose of Infliximab > 3 mg/kg	1.7	0.04
Infliximab	0.95	0.34
Adalimumab	0.9	0.72
Tocilizumab	0.8	0.25

Conclusions: Our study showed that RA patients were exposed to a higher risk of TB, especially when using anti TNF therapy with increased incidence of extra pulmonary TB. Understanding associated factors with TB may lead to establish a continuous monitoring in order to improve the quality of care.

Disclosure of Interest: None declared

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AB1055

BRUCCELLAR SPONDYLODISCITIS: DO MRI SIGNS OF SEVERITY INFLUENCE THE DURATION OF THE TREATMENT

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Background: Brucellar spondylodiscitis is rarely associated with neurological involvement. Magnetic resonance imaging has high sensitivity for detecting the paravertebral and epidural extension

Objectives: The purpose of this study was to determine the influence of the MRI severity signs on the treatment duration

Methods: A retrospective study of 27 patients with Brucellar spondylodiscitis during a period of 17 years [2000–2016] was performed. Diagnosis was made on clinical presentation, laboratory findings, radiographic evidence and Brucellar seroagglutination tests. Three patients underwent CT scans and a spinal MRI was carried out for 24 patients. All of them received antibiotic treatment based on a combination of Rifampicin and Doxycycline of varying duration

Results: Ten women and 17 men were included. The mean age was 54 years. Twenty-six patients suffered from spinal pain (96.3%) and 12 patients had radiculalgia (44.4%). The lumbar spine was the most frequently involved region (59.3%), followed by the dorsal spine (18.5%) and the cervical spine (11.1%). The

neurological examination showed no abnormalities. Spinal MRI showed paravertebral abscess in 56.5% of cases. Seventeen patients (73.9%) had epiduritis and 9 patients (39.9%) had spinal cord compression on the MRI. An abnormal signal of the spinal cord was observed in 2 cases (8.7%). All patients received a combination of Rifampicin and Doxycycline. The mean duration of the antimicrobial treatment was 8 months. There was no statistically significant association between the occurrence of abscesses, epiduritis, spinal cord compression, abnormal signal of the spinal cord on the MRI and the duration of treatment ($p=0.935$, $p=0.929$, $p=0.379$, $p=0.889$ respectively).

Conclusions: MRI of the spine frequently revealed signs of severity in brucellar spondylodiscitis patients, although without clinical expression. Despite their severity these signs did not result in a longer period of antibiotic therapy

Disclosure of Interest: None declared

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AB1056 DIAGNOSIS VALUE OF PERCUTANEOUS SPINAL NEEDLE BIOPSY IN BRUCELLAR SPONDYLODISCITIS

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Background: spondylodiscitis is a serious condition with a large variety of infectious etiology. Vertebral biopsy is needed to perform the microbiologic diagnosis when no causative organism is identified. CT-guided percutaneous spinal biopsy (CTSB) may reduce the risk of contamination and complications.

Objectives: The aim of this study is to determine the contribution of CTSB to the diagnosis of Brucellar spondylodiscitis.

Methods: we conducted a retrospective study on 27 patients admitted for Brucellar spondylodiscitis over a 17 years period [2000 to 2016]. The etiological diagnosis was based on Brucella agglutination test which was positive for all patients. Twelve patients had a CTSB with cytobacteriological and histological tests.

Results: twenty seven patients (17 men and 10 women) with a mean age of 54 years were included. Twenty six patients (96.3%) reported a spinal pain. This pain involved the lumbar spine (59.3%), the dorsal spine (18.5%) and less frequently the cervical spine (11.1%). Eight patients reported lombosciatica (29.6%). An etiological doubt subsisted in 12 cases and a CTSB was performed. Culture results were negative for 11 biopsy samples and one culture was positive to Staphylococcus in a case of a co-infection. The results of the histological examination showed chronic non-specific inflammation in 92.3% of cases. An infectious etiology was suspected histologically in 53.8% of cases and particularly of a pyogenic germ (23.1%). The biopsy was not contributive in one case

Conclusions: Our results suggest that CT-guided spinal biopsy is not useful to diagnose Brucellar spondylodiscitis. However, the absence of tubercloid granuloma and caseous necrosis helped ruling out the tubercular origin

Disclosure of Interest: None declared

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AB1057 BRUCELLAR SPONDYLODISCITIS: THE IMAGING FINDINGS

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Background: Brucellar spondylodiscitis is an important complication of brucellosis that can cause neurologic involvement and spinal deformities if not appropriately treated. Imaging examination is a major key in diagnosis

Objectives: The aim of this study was to report the imaging findings in brucellar spondylodiscitis

Methods: We performed a retrospective study including 27 patients with Brucellar spondylodiscitis over a period of 17 years from 2000 to 2016. Diagnosis was made on clinical presentation, laboratory findings, radiographic evidence and Brucellar seroagglutination tests. All patients underwent X-rays of the involved spine levels. Spinal computed tomography (CT) was carried out in 13 cases and spinal MRI in 24 cases

Results: seventeen men and 10 women aged from 33 to 75 years were included. Plain radiographs showed a disc space narrowing for 26 patients (96.3%) and an irregularity of the vertebral end plate in 16 cases (59.3%). A paravertebral abscess formation was detected for 3 patients. No obvious abnormalities were found in one case. CT scans of most patients revealed signs of spondylodiscitis (92.3%). This examination showed an erosion of the vertebral end plates (69.2%), intervertebral disc space narrowing (61.5%) and bone destruction (38.5%). The severity signs detected on the CTs were the soft tissue thickening (46.2%), abscesses formations (7.4%), epiduritis (30.8%) and one patient had a spinal cord compression. The 24 MRIs realised exhibited a signal abnormality of the vertebral body (95.7%) and the intervertebral disc (47.8%) in addition to disc space narrowing (73.9%) with erosions of the vertebral end plates (56.0%). The contrast enhanced T1-

weighted images showed marked enhancement of affected vertebrae and disc (78.3%). Thirteen patients had abscesses formations (56.5%), 17 had epiduritis (73.9%) and 9 patients (31.9%) presented a spinal cord compression on MRI. Brucellar spondylodiscitis involved one spinal level in 23 cases whereas multilevel involvement was found in the 4 others

Conclusions: plain radiographs and spinal CT scans lack sensitivity in diagnosing brucellar spondylodiscitis and spinal MRI remains the referential imaging modality to recognise early bone infection, allowing complete lesion topography and identifying the complications.

Disclosure of Interest: None declared

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AB1058 IS HEPATITIS B SURFACE ANTIGEN (HB S AG) ENOUGH ALONE AS A SCREENING TEST FOR HBV INFECTION IN RHEUMATIC DISEASE PATIENTS BEFORE STARTING IMMUNOSUPPRESSIVE THERAPIES?

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Background: Prevalence of hepatitis B virus in patients with rheumatic diseases has been reported differently among studies. The loss of immune control in these patients may result in the reactivation of HBV replication within hepatocytes. Considering the lifelong use of multiple anti-rheumatic drugs, screening for HBV is recommended before starting immunosuppressive or immunomodulatory therapy.

Objectives: The aim of this study was to select the best and simplest test for screening of HBV in rheumatic patients in Egypt.

Methods: This cross sectional study was carried out on 102 patients with different rheumatic diseases. Screening to all patients by hepatitis B surface antigen (HBsAg), hepatitis C virus (HCV) and human immune deficiency virus antibodies (HIV) were done. HBV core antibodies and real time PCR to detect HBV DNA were done.

Results: The mean age of the patients was 37.18 ± 12.37 . 3.9% of them were males and 96.1% were females. We found that HBsAg was positive in two patients (2%) and negative in 100 patients (98%). HBcAb was positive in 24 patients (23.5%) and negative in 78 patients. however PCR for hepatitis B DNA was positive in 2 patients (2.0%) only who were positive for both HBsAg and HBcAb. HBsAg had 100% Sensitivity, 100% Specificity, 100% PPV, 100% NPV and 99.0% accuracy. While antiHBc had 100% Sensitivity, 78% Specificity, 8% PPV, 100% NPV and 78% accuracy in screening of HBV.

Abstract AB1058 – Table 1. Serological diagnosis of HBV in rheumatic disease patients

	Negative No%	Positive No%	Total (n=102) No%
Anti-HBc:	78 76.5	24 23.5	102 100.0
HBs Ag	100 98.0	2 2.0	102 100.0
PCR	100 98.0	2 2.0	102 100.0

Abstract AB1058 – Table 2. The validity of HBsAg and HBcAb in relation to HBV DNA by PCR

validity of HBs-Ag in relation to PCR in diagnosis of HBV				
Sensitivity	Specificity	PPV	NPV	Accuracy
100.0%	100.0%	100.0%	100.0%	99.0%
validity of AntiHBc Ab in relation to PCR in diagnosis of HBV				
Sensitivity	Specificity	PPV	NPV	Accuracy
100.0%	78.0%	8.0%	100.0%	78.0%

Abstract AB1058 – Figure 1. Receiver operating characteristic (ROC) plot for "HBs Ag in relation to PCR in diagnosing HBV" on the left side & "HBc Ab in relation to PCR" on the right side.

Conclusions: We can conclude that screening for hepatitis B virus is essential for all patients with rheumatic diseases before starting therapies either steroids, immunosuppressive therapies or biologics. For financial issues especially in developing countries screening by HBsAg may be enough as an initial test especially if non biological therapies are used as it is superior to anti HBc for screening for HBV infection.

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Disclosure of Interest: None declared

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AB1059

CONTRIBUTION OF CT-GUIDED DISCOVERTEBRAL BIOPSY DURING INFECTIOUS SPONDYLODISCITIS

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Background: Infectious spondylodiscitis is an infection involving the vertebral endplates and the intervertebral discs. The diagnosis is based on a combination of clinical symptoms, biological and radiological findings. Identifying the causative germ is sometimes difficult and a CT-guided discovertebral biopsy (DVB) might be of help, with varying success rates.

Objectives: The aim of this study was to assess the contribution of CT-guided DVB in the diagnosis of infectious spondylodiscitis in a rheumatological environment in Tunisia.

Methods: A retrospective study including patients diagnosed with infectious spondylodiscitis in the rheumatology department of Farhat Hached hospital, Sousse, Tunisia, between 1998 and 2017. Only patients who underwent a DVB for etiologic diagnosis of infectious spondylodiscitis were included in this study.

Results: Thirty five patients, with 12 (34.3%) women, were included. The mean age was 57.31±19.14 years [15–83 years]. All patients presented with back pain for 83.06±73.32 days [10–330 days], seven (20%) patients had fever and six (17.1%) patients had abnormal neurological signs on examination. The mean WBC, CRP and ESR levels were respectively 8170.83±3476.94 elements/mm³, 50.22±59.22 mg/L and 86.85±50.74 mmh1. The affected levels were the lumbar in 23 (65.7%) cases and dorsal spine in 9 (25.7%) cases. Three patients (8.6%) had both dorsal and lumbar spondylodiscitis.

First DVB was contributive in 11 (31.4%) cases. Isolated germs were staphylococcus aureus in 4 (36.4%) cases, tuberculosis in 3 (27.3%) cases, and brucellosis, coagulase negative staphylococcus, enterobacter cloacae, streptococcus oralis in one case each. Only one patient underwent a second DVB attempt, which was contributive, isolating a staphylococcus aureus. The rest of patients were treated based on late bacteriological findings (2 cases of brucellosis, 2 cases associated with Escherichia coli urinary infection and 1 case with pulmonary tuberculosis), or presumption arguments (6 cases treated as pyogenic infection and 12 cases as tuberculosis).

Conclusions: DVB remains essential for the positive diagnosis of infectious spondylodiscitis. Nevertheless, its bacteriological insufficient contribution should not delay therapeutic management based on presumption arguments.

Disclosure of Interest: None declared

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AB1060

WHIPPLE DISEASE WITH INITIAL PRESENTATION AS NON-EROSIVE SERONEGATIVE POLYARTHRITIS: A CASE REPORT FROM A SINGLE CENTRE

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Background: Whipple disease (WD) is a rare disease caused by the bacterium *Tropheryma whipplei* (TW), which manifestations may range from joint and GI tract involvement to severe neurological complications.

Objectives: To present a clinical case of WD with non-erosive seronegative polyarthritis, sacroiliitis, abdominal and CNS involvement, and immune reconstitution inflammatory syndrome after antibiotic therapy.

Methods: Case report. Prospective follow-up of the patient E. with WD, who was diagnosed HLA-B27-negative nonerosive seronegative rheumatoid arthritis in 2013. The disease was partially responsive to glucocorticoids with temporary effect to different DMARDs (MTX, leflunomid, etanercept, abatacept, tocilizumab either as monotherapy or in combination).

Results: A 54 y.o. male patient E. was admitted to the Rheumatological department with complaints of joint swelling, low back pain, weight loss, diarrhoea, headache and low grade fever. Peripheral joint arthritis appeared about 4 years ago with progressive worsening of general condition and development of additional complaints during the past year. From 2013 to 2017 the patient received in-hospital and outpatient treatment because of active seronegative polyarthritis without sufficient effect. On admission: clinical examination and joint ultrasound (US) investigation revealed the signs of polyarthritis. Neurological evaluation showed organic psychiatric disorder with signs of pseudodementia, bradykinesia without focal neurological deficits.

Because of both incomplete responsiveness to DMARD-therapy and suspicion of chronic infection or malignant neoplasm, abdominal US and transthoracic echocardiography, gastroscopy, colonoscopy, immunofixation, bone marrow biopsy, chest X-ray and bone scintigraphy, tests for viral hepatitis (B,C), HIV, Lues and QFT-Tb were performed, however without objective evidence of the cause. PET-CT was performed as well, but showed no signs of malignancy or infection. MRI revealed bifrontal brain atrophy, low-grade bilateral sacroiliitis and degenerative changes of the cervical spine.

For differential diagnosis PCR stool investigation for TW was performed and was positive. Upon the suspicion of WD duodenoscopy with duodenal biopsy were done. Histological examination showed PAS-positive macrophages, typical for WD. Immunohistochemical analysis also supported the diagnosis. PCR investigation of liquor and synovial fluid from ankle joint for TW were also positive. Antibiotic treatment using a 2 week course of parenteral Ceftriaxon 2 g/day was initiated. On the third day of the treatment the patient developed immune reconstitution inflammatory syndrome with febrile temperature and increased inflammatory markers. The symptoms regressed after additional prednisolon 20 mg/day prescription. Because of organic brain syndrome, administration of Co-trimoxazole was recommended. Under the antibacterial therapy the patient had rapid positive response. PCR stool test in October 2017 didn't detect TW.

Conclusions: This presentation emphasises the importance of excluding a rare infection as a cause of atypical inflammatory arthropathy. In patients with seronegative rheumatoid arthritis or axial and peripheral spondyloarthritis, who don't adequately response to immunosuppression, Whipple disease should be taken into account.

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MULTIFOCAL SPONDYLODISCITIS IN IMMUNOCOMPETENT PATIENTS

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Background: The prevalence of Infectious spondylodiscitis (SPD) has decreased recently with the development of effective means of prevention. Multifocal forms are more common in immunocompromised persons, but may be seen in immunocompetent ones. They are severe, and fortunately remain rare.

Objectives: The aim of our study was to report the clinical, biological, radiological and therapeutic features of multifocal SPD in immunocompetent patients.

Methods: A retrospective study was performed including patients hospitalised in the department of rheumatology between January 2007 and December 2017. Clinical data, laboratory findings and radiologic features were evaluated.

Results: Six patients were included. Their mean age was 53 years.^{34–81} No comorbidities were found in all patients. The interval between the beginning of the symptomatology and the diagnosis was 3 to 6 months. Fever was noticed in 4 cases. All the patients had inflammatory spinal pain. Two patients had neurologic deficiency: one spinal compression and one root compression. The localization of the infection was lumbar and thoracic in 3 cases, cervical in 1 case and lumbar in 2 cases. MRI showed epiduritis in 3 cases and paravertebral abscess in 1 case. The infectious agent was identified by blood cultures in 1 case (*Staphylococcus Aureus*), by disco vertebral biopsy in 3 cases (tuberculosis) and by brucella serology in 2 cases. All patients underwent antibiotic therapy and immobilisation with a good outcome, only one patient needed surgery aiming to decompress the spinal cord. Investigation for immunodeficiency was negative in all patients.

Conclusions: Multifocal SPD in immunocompetent patients remains rare. Its etiology is dominated by tuberculosis. The most frequent localizations are lumbar and thoracic spine.

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