neurological examination showed no abnormalities. Spinal MRI showed paraver-
tebral 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 combi-
nation of Rifampicin and Doxycycline. The mean duration of the antimicrobial
therapy was 8 months. There was no statistically significant association
between the occurrence of abscesses, epiduritis, spinal cord compression, abnor-
mal 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


AB1056

DIAGNOSIS VALUE OF PERCUTANEOUS SPINAL NEEDLE BIOPSY IN BRUCELLAR SPONDYLODICITIS

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Background: spondylodiscitis is a serious condition with a large variety of infec-
tious 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 Brucel-
lar spondylodiscitis over a 17 years period (2000 to 2016). The etiological diagno-
sis was based on Brucella agglutination test which was positive for all patients.

Results: Twelve patients had a CTSB with cytobacteriological and histological tests.

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

Disclosure of Interest: None declared


AB1057

BRUCELLAR SPONDYLODICITIS: THE IMAGING FINDINGS

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Background: Brucellar spondylodiscitis is an important complication of brucello-
sis that can cause neurologic involvement and spinal deformities if not appropri-
ately 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 Brucel-
lar spondylodiscitis over a period of 17 years from 2000 to 2016. Diagnosis was
made on clinical presentation, laboratory findings, radiographic evidence and Bru-
eliac 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
formations were 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%), interve-
tebral disc space narrowing (61.5%), and bone destruction (38.5%). The seventy
signs detected on the CTs were the soft tissue thickening (46.2%), abscesses for-
mations (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 vertebral 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. Bru-
cellar spondylodiscitis involved one spinal level in 23 cases whereas multilevel
involved was found in the 4 others

Conclusions: plain radiographs and spinal CT scans lack sensitivity in diagnos-
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


AB1058

IS HEPATITIS B SURFACE ANTIGEN (HB S AG)
ENOUGH ALONE AS A SCREENING TEST FOR HBV
INFECTION IN RHEUMATIC DISEASE PATIENTS

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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. Con-
sidering the lifelong use of multiple anti-rheumatic drugs, screening for HBV is rec-
commended 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%). HBeAb 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 HBeAb. HBsAg had 100% Sensitivity, 100% Specificity, 100% PPV, 100% NPV and 99.0% accuracy. While anti Hbc 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

<table>
<thead>
<tr>
<th>Test</th>
<th>Negative</th>
<th>Positive</th>
<th>Total (n=102)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-HBc</td>
<td>78.76</td>
<td>24.23</td>
<td>102.00</td>
</tr>
<tr>
<td>HBs Ag</td>
<td>100.0</td>
<td>2.0</td>
<td>102.00</td>
</tr>
<tr>
<td>PCR</td>
<td>100.0</td>
<td>2.0</td>
<td>102.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Test</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>PPV</th>
<th>NPV</th>
<th>Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBsAg</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.0%</td>
</tr>
<tr>
<td>HBeAg</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.0%</td>
</tr>
</tbody>
</table>

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