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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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.

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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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AB1061

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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