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.

REFERENCES:

Disclosure of Interest: None declared


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 [15–86 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 for 23 (65.7%) cases and dorsal spine in 9 (25.7%) cases. Three patients (8.6%) were also positive. Antibi- 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 reconstituti- tion inflammatory syndrome with febrile temperature and increased inflamma- tory markers. The symptoms regressed after additional predonisol 20 mg/day prescription. Because of organic brain syndrome, administration of Co-trimoxa- zole 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 underlines the importance of excluding a rare infection as a cause of atypical inflammatory arthropathy. In patients with seve- re rheumatoid arthritis or axial and peripheral spondyloarthropathies, who don’t adequately respond to immunosuppression, Whipple disease should be taken into account.

Disclosure of Interest: None declared


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. Multifo- cal 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. 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 deficit: 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 bronchial sero- logy in 2 cases. All patients underwent antibiotic therapy and immobilisation with a good outcome. Only one patient needed surgery due to degeneration of the spinal cord. Investigation for immunodeficiency was negative in all patients.

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

Disclosure of Interest: None declared