Conclusion: Our study showed that there was no correlation between the clinical condition of patients and their follow-up imaging in the context of PVO. Clinical and biological evaluation seems sufficient to determine whether or not the patient is cured. Many images are made during the follow-up with a questionable cost/effectiveness ratio. A standard radiograph may be sufficient to provide a basic structural condition at the end of antibiotic therapy.

Disclosure of Interests: None declared


SAT0463

BRUCELLAR SPONDYLODISCITIS: CLINICAL, RADIOLOGICAL AND THERAPEUTIC FEATURES

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Background: Brucellosis is an endemic disease around the Mediterranean and especially in Tunisia and Brucellar spondylodiscitis is the most common osteoarticular localization.

Objectives: The aim of our study is to study the clinical, radiological and therapeutic characteristics of Brucellar spondylodiscitis.

Methods: This is a retrospective descriptive study, conducted over 20 years (1999-2019) at a Rheumatology Department. We collected cases of Brucellar spondylodiscitis. We studied the clinical, radiological features and therapeutic outcomes.

Results: We included 23 patients, 15 men and 8 women, with a mean age of 53.21 years [31.79]. Contact with livestock or consumption of raw milk was noted in 16 cases. The diagnosis time was, on average, 3.8 months [1.9]. Spine pain was present in all cases, with lumbar seat in 16 cases and was inflammatory in 20 cases. At the examination, 19 patients had a limitation of spinal mobility and 4 had neurological abnormalities. A motor deficit with a horsetail syndrome was objectified in one case. We noted a biological inflammatory syndrome in 19 cases. Wright’s serology was positive in 21 cases. Standard radiographs showed disc narrowing in 10 cases, 21 patients had spinal magnetic resonance imaging showing the abnormalities of the disc and adjacent vertebrae. We found abscesses in four patients and epiduritis associated with the abscesses in six patients. MRI showed spinal compression in 2 patients. Disco-vertebral biopsy was performed in 11 cases and helped to make the diagnosis in 3 cases. The patients had received antibiotic therapy with a combination of doxycycline and rifampicin with a mean total duration of 6 months.

Conclusion: Brucellar spondylodiscitis can be serious because of the neurological complications that it can cause. At the slightest diagnostic doubt, many images are made during the follow-up with a combination of doxycycline and rifampicin with a mean total duration of 6 months. Brucellar spondylodiscitis is a manageable disease with treatment.

Disclosure of Interests: None declared


SAT0464

HEPATIC SAFETY OF ANTI-TUBERCULOUS TREATMENT IN SPONDYLODISCITIS

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Background: Tunisia is considered as a country with high tuberculosis endemicity. The anti-tuberculous treatment is quite long and binding and requires close hepatic monitoring.

Objectives: The purpose of this study was to highlight the hepatic safety of anti-tuberculosis treatment in tuberculous spondylodiscitis.

Methods: This is a retrospective descriptive study, over 20 years (1999-2019) collating cases of tuberculous spondylodiscitis in a rheumatology department. We studied the epidemiological, clinical, radiological and therapeutic aspects.

Results: Our study included 62 patients, 35 women and 27 men. Mean age of patients was 46.8 years [16-86]. The diagnosis delay averaged 5.59 months [0.23-24]. Tuberculous contact was noted in 11.3% of the cases. Neurological abnormalities were noted in 16,1% of cases with spine compression in 3,22%. The tuberculosis skin test was positive in 29 cases and the Koch bacillus investigations in the sputum and the urine were positive in only 3 patients. Magnetic resonance imaging was performed in 71% of the patients, and mainly showed images of disc destruction with images of abscess, epiduritis and epidual extension. Infectious spondylodiscitis affected the lumbar spine in 66,1% of the cases, the dorsal spine in 14,51% of the cases and the cervical spine in 6,55% of the cases.

Conclusion: Our study showed that there was no correlation between the clinical condition of patients and their follow-up imaging in the context of PVO. Clinical and biological evaluation seems sufficient to determine whether or not the patient is cured. Many images are made during the follow-up with a questionable cost/effectiveness ratio. A standard radiograph may be sufficient to provide a basic structural condition at the end of antibiotic therapy.

Disclosure of Interests: None declared


SAT0465

VALUE OF SERUM PROCALCITONIN FOR THE DIAGNOSIS OF BACTERIAL SEPTIC ARTHRITIS IN DAILY PRACTICE IN RHEUMATOLOGY

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Background: Septic arthritis is a diagnostic and therapeutic emergency because of a high morbidity and mortality. Nevertheless, the etiologic diagnosis is often difficult.

Objectives: The aim of our study was to determine if serum procalcitonin was a discriminatory biomarker in case of arthritis of undetermined etiology.

Methods: Patients were separated in 5 groups: gouty arthritis, calcium pyrophosphate deposition arthritis, osteoarthritis or post-traumatic arthritis (“mechanical” arthritis), chronic inflammatory rheumatic arthritis, and septic arthritis. Levels of serum with blood cells, C-Reactive Protein and procalcitonin were measured.

Results: 98 patients were included: 18 in the “gout” group, 26 in the “calcium pyrophosphate deposition arthritis” group, 16 in the “mechanical” group, 18 in the “chronic inflammatory rheumatic” group and 20 in the “sepsis” group. The area under the receiver operating characteristic curve of with blood cells, C-Reactive Protein and procalcitonin levels to diagnose a septic arthritis was 0.69 (IC95% 0.56-0.83), 0.82 (IC95% 0.73-0.91), and 0.87 (IC95% 0.76-0.98) respectively. For a cut-off of 0.5 ng/ml, procalcitonin sensitivity, specificity, positive predictive value, negative predictive value, positive likelihood ratio and negative likelihood ratio were 65%, 91%, 65%, 91%, 7.2 and 0.4, respectively. Serum C-Reactive Protein and procalcitonin levels were correlated, were not different in septic arthritis with poly-arthritis than with mono-arthritis (p<0.05).

Conclusion: Serum procalcitonin is a useful biomarker in arthritis management with diagnosis performances higher than those of other biomarkers (with blood cells, C-Reactive Protein).

Disclosure of Interests: None declared


SAT0466

PNEUMOCOCCAL CELLULITIS AND FASCIITIS IN SYSTEMIC LUPUS ERYTHEMATOSUS: A SYSTEMATIC REVIEW

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Background: Streptococcus pneumoniae (SPN) is an encapsulated gram-positive bacterium that can be found in the nasopharynx as part of the normal flora. However, is the most common cause of community-acquired pneumonia in adults and can also cause invasive diseases such as bacteremia, meningitis, and otitis media. Pneumococcal cellulitis and fasciitis...
are uncommon. Several factors are associated with a predisposition to infections in patients with Systemic Lupus Erythematosus (SLE).

Objectives: To describe and analyze all documented cases of cellulitis or fasciitis caused by SPN in SLE patients.

Methods: In the framework of the study of a 24-years-old woman that during the SLE onset presented left tight cellulitis and fasciitis caused by SPN, a systematic review was conducted (until September 2018). The search included terms to identify any SPN infection in SLE patients and all those articles that reported cellulitis or fasciitis were selected (Table 1).

Table 1. flow chart.

| Total searched articles: | 313 |
| - Medline 72, Embase 241, Cochrane 0. |
| - Duplicated 23. |
| - Selected: 8 |

Manual included articles: 1.

Results: A total of 313 articles were obtained. Eight of them (1-8) and 1 article identified in a manual search (9) described a total of 15 cases presenting SLE and cellulitis or necrotizing fasciitis caused by SPN; our case is the 16th described.

Documented infections (n=16):
- - Cellulitis (n=8): neck, face or chest (n=5, 62.5%); extremities (foot or hand) (n=2, 25%); breast (n=1, 12.5%).
- - Fasciitis (n=8): neck, face at chest (n=5, 62.5%); tights (n=3, 37.5%).

Description of the documented cases:
- Demographic characteristics (n=13): female sex (n=11, 85%); <30 years of age at the moment of the infection (n=11, 85%).
- Time of SLE evolution at the moment of the infection (n=9): ≤ 1 month (n=3, 33.3%); ≤ 3 years (n=3, 33.3%); ≥ 8 years (n=3, 33.3%).
- Associated conditions (n=12): previous high doses of prednisone (n=5, 41.6%); recent respiratory symptoms (n=4, 33.3%); renal insufficiency (n=2, 16.6%); previous SPN infections (n=1, 8.3%); recent surgery in the affected area (n=1, 8.3%).
- Microbiological diagnosis (n=12): blood cultures (n=11, 91.6%); other cultures (n=5, 41.6%).
- Treatment (n=12): beta-lactams (n=12, 100%); intensive care support (n=6, 50%); surgical debridment (n=5, 41%).
- Outcome (n=15): death (n=2, 20%); recurrent SPN infections (n=2, 13.3%).

Conclusion: - Pneumococcal cellulitis and fasciitis in SLE were predominantly presented in young women and in a high rate of cases during the disease onset.
- Almost half of the cases were previously treated with high doses of steroids. Nevertheless, no other potential predictors of pneumococcal cellulitis or fasciitis were identified; in addition, only one patient presented a previous surgery in the affected anatomical area, previous trauma were not described in any case, and a low number of cases reported associated respiratory symptoms. This supports the importance of the intrinsic immune dysregulation in SLE patients.
- Pneumococcal cellulitis and fasciitis in SLE patients present poor prognosis, requiring intensive care support and surgical debridement in a high rate of cases, and presenting a fatal outcome in a fifth of them.

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