Abstract AB1081 Table 2. characteristics of SAPHO syndrome and AS patients with spinal involvement

characteristics	SAPHO (n=34)	AS (n=50)	P value
Sex, female	21(61.8%)	17(34.0%)	0.012*
Age at onset, yrs	52.2±10.3	35.4±12.0	0.0008*
Disease duration, yrs	6.1±7.1	7.4±7.3	NS
CRP elevated	16(46.12.1)	26 (2.11 ±2.52)	NS
ESR elevated	16 (31.2±24.0)	18 (28.4 ±24.6)	NS
HLA-B27 positive	1(2.9%)	48(96.0%)	0.000*
Cervical vertebra	17(50.0%)	13(26.0%)	0.024*
Thoracic vertebra	22(64.7%)	33(66.0%)	NS
Lumbar vertebra	17(50%)	34(68.0%)	NS
Contiguous/multiple vertebra involvement	28(82.4%)	50(100%)	0.002*
Vertebral inflammation	34(100%)	48(96.0%)	NS
Endplate inflammation	8(23.5%)	3(6.0%)	0.019*
Spondylodiscitis	16(47.1%)	4(8.0%)	0.001*
Vertebral body corner involvement	11(32.4%)	13(26.0%)	NS
Paravertebral ossification	4(11.8%)	5(10.0%)	NS

All the SAPHO patients with spinal involvement were followed up. 30 patients received NSAIDs plus DMARDS/biologics and the symptoms improved. Reexamined imaging data of 10 patients were available and the spinal involvement became better.

Conclusion: 73.9% of SAPHO patients had spinal involvement and they were more likely to suffer from cervical spine involvement, endplate inflammation and spondylodiscitis. The combination of NSAIDs and biologics/DMARDS were helpful to improve the symptoms.

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AB1082 IATROGENIC INFECTIOUS SPONDYLODISCITIS: 6 CASES

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Background: The increasing proportion of iatrogenic spondylodiscitis (SD) is a prominent feature of infectious DS in recent decades

Objectives: To describe iatrogenic clinical, aetiological and evolutive SD features.

Methods: We report 6 cases of iatrogenic DS collected in our department in 2001-2012 period.

Results: All patients were male. The average age was of 49 (35 to 68 years). Four cases of SD were caused by direct inoculation (surgical in 3 cases, chemonucleolysis in 1 case) and 2 cases of hematogenous SD from an initial outbreak. The seat of infection is lumbar in all cases. Spinal pain is almost constant. The admission examination noted apyrexia in 5 cases. A biological inflammatory syndrome was present in 5 cases and hyperleucocytosis in 2 cases. The bacteriological investigation was able to isolate a methicillin-sensitive *Staphylococcus aureus* (SAMS) and a *proteus mirabilis* in one patient and SAMS in another. The radiological assessment made it possible to objectify a para vertebral abscess in 5 cases and an epididitis in 1 case. The evolution was favorable in all cases under antibiotherapy of average duration of 4.5 months and immobilization of the spine by corset.

Conclusion: The detection of an anaerobic germ causing infectious spondylodiscitis should search for an iatrogenic portal chronologically and anatomically close to the vertebral disc infection.

Disclosure of Interests: None declared

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AB1083

IN A FAMILIAL MEDITERRANEAN FEVER PREVALENT REGION, ARE FAMILIAL MEDITERRANEAN FEVER AND BEHÇET'S DISEASE ASSOCIATED?

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Background: The co-existence of Familial Mediterranean Fever (FMF) and Behçet's Disease (BD) has been questioned. There have been a variety of claims on a common pathogenesis.

Objectives: We intended to report the prevalence of Familial Mediterranean Fever (FMF) and Behçet's disease (BD) and comorbidity ratio of these two diseases in Sivas, Turkey, a city where FMF is known to be very high.

Methods: Seventy-two primary schools in the center of Sivas participated in the study. A total of 14881 randomized sample children from 6th, 7th, and 8th grades, and also 985 of them with their parents (n: 978) were interviewed. During these interviews, the family tree up to second degree relatives was drawn. The presence of a diagnosis of FMF or BD was questioned. The ones who have a diagnosis were confirmed by contacting the medical centers. The ones who were suspected of a disease were further investigated at Sivas Cumhuriyet University Medical Faculty, Family Medicine Outpatient unit. For each disease a disease related history, physical examination, eye examination and pathergy test for BD were performed when needed.

Results: 985 students, 978 mothers, 953 fathers and 1876 relatives (4792 in total) were included in the study. Only 30 (0.6%) of the sample was diagnosed with FMF, and 3 (%0.06) was diagnosed with BD. One of them had concomitant FMF diagnosis.

Table. FMF symptoms within the last year

Symptoms	N	%
Abdominal Pain	20	66.7
Fever	23	76.7
Joint Pain	8	26.7
Chest Pain	10	33.3
Muscle Pain	7	23.3
Erysipelas like erythema	5	16.7

Conclusion: The prevalence of FMF in Sivas is higher than Turkey's prevalence; however, BD prevalence was found very low. According to these findings, it is not easy to conclude that these two diseases share a similar background of pathogenesis.

Disclosure of Interests: None declared

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AB1084

PECULIARITIES OF ERYTHEMA NODOSUM ASSOCIATED WITH SARCOIDOSIS AND BACTERIAL-VIRAL INFECTION IN RHEUMATOLOGIST PRACTICE

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Background: Erythema nodosum (EN) is a nonspecific immune inflammatory syndrome, which is a septal panniculitis without vasculitis. Often EN acts as one of the symptoms of systemic pathology, which can cause late diagnosis and, accordingly, the appointment of adequate therapy.

Objectives: to study clinical, laboratory and radiological data in EN in the acute form of sarcoidosis (SAR) and EN associated with bacterial and viral infection in patients sent to the rheumatology center.

Methods: The study included 312 patients (61 men and 251 women, age 35.4 ± 8.2 years) who applied to the clinic with a referral diagnosis of EN in 2007-2017. The median duration of the disease was 1.6 [0.3;4.7] months. All patients underwent a comprehensive clinical examination and laboratory and instrumental examination of biochemical, serological (ASL-O, antibodies against chlamydia and Mycoplasma of 2 classes, ureaplasmas, herpes viruses of type I and II, cytomegalovirus, Epstein-Barr virus, hepatitis B/C, Yersinia, HIV, etc.) and immunological parameters, radiography or computed tomography (CT) of the chest organs.

Results: 145 patients (46.4%) were diagnosed with SAR (34 men and 111 women). EN associated with bacterial-viral infection was detected in 167 patients (53.5%). Serological examination of these patients showed an increase of ≥ 3 times the levels of antibodies to Herpesviridae (79 people), *M. pneumoniae* (15), *CL. Pneumonia* (11), *Y. enterocolitica* (11), *Chl. trachomatis* (9), *M. hominis* (6), increase of ASL-O (57). EN with SAR is characterized by: the duration of the disease up to 6 months (odds ratio (OR) 7,320, 95% confidence interval (CI) 2,297–23,329, $p < 0.005$), multiple diffuse lesions on the legs and single diffuse lesions on the thighs and/or forearms (OR 15,500, 95% CI 1,983–121,132; $p < 0.005$), lesions of ankle joints (OR 35,905, 95% CI 9,523–135,365; $p < 0.005$), high CRP level (OR 5,429 95% CI: 2,164–13,618; $p < 0.005$). Predictors of the formation of the CT phenomenon of “frosted glass” in ATS were male sex (OR 6.5; DI 1.2–35; $p = 0.026$) and the presence of conglomerates of nodes (OR 4.8; DI 1.4–16.1; $p = 0.01$). Postinfectious EN was characterized by its development typically before the age of 30 (OR 0.825, 95% CI 0.328–2.077, $p < 0.005$), the symptom of “blooming” bruise (OR 0.028, 95% CI 0.009–0.092, $p < 0.005$), an increase in antistreptolysin-O (OR 0.035, 95% CI 0.006–0.207, $p < 0.005$). Within 1 year of follow-up, 72% of patients with SAR EN did not relapse, and the joint syndrome almost completely regressed. Postinfectious EN recurred within 1 year in 38 people due to: exacerbation of chronic tonsillitis (14), ARVI/hypothermia (10), stress (5), violation and ineffectiveness of prescribed therapy (9).

Conclusion: Post-infectious EN is somewhat more common than EN in SAR. The latter is characterized by greater severity of clinical parameters and high parameters of inflammatory activity. These features should be borne in mind when carrying out differential diagnosis in patients with EN.

Disclosure of Interests: None declared

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AB1085 OSTEO-ARTICULAR MANIFESTATIONS OF SARCOIDOSIS: ABOUT 13 CASES

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Background: Sarcoidosis is a systemic disorder of unknown etiology, affecting the respiratory tract and the lymphatic system with predilection. It is an ubiquitous condition whose clinical phenotype is very diverse.

Objectives: To detail the epidemiological, clinico-biological, therapeutic and evolutionary features of osteoarticular forms of sarcoidosis.

Methods: This is a monocentric, descriptive retrospective study conducted over a 17-years period [2002-2018] involving 13 patients diagnosed with sarcoidosis with osteoarticular manifestations at the department of Rheumatology at Farhat Hached University Hospital in Sousse.

Results: 13 patients with osteoarticular manifestations were studied; this was indicative of the disease in 8 cases (61.5%). The sex ratio was 0.23 with a mean age of 42.38 years and a diagnostic delay of 12 months. In 77% of cases, inflammatory arthralgia was noted, Löfgren syndrome (30.7%), chronic polyarthritis (30.7%), phalanges cystoid osteitis (15.4%) and no cases of monoarthritis. The extra articular manifestations found were: Adenomegaly (92.3%), lung (77%), cutaneous (38.5%) (including 80% erythema nodosum), neurological (30.7%) (Aseptic meningitis and convulsion), ocular (23%) (chorioretinitis, keratoconjunctivitis and retro-bulbar optic neuritis), cardiac (15.4%), and biological hepatitis (7.7%). In the biology, a biological inflammatory syndrome was found in 30.7% with a mean sedimentation rate of 31.07 in the 1st hour, an average CRP of 9 mg/L, cholestasis and cytolytic found in 15.4% and 7.7%, respectively. No Hypercalcemia was noted. The value of the conversion enzyme was high in 5 out of 6 patients who were dosed with an average of 71 $\mu\text{g/L}$. In imaging, sarcoidosis was destructive in 4 cases; A multifocal osteonecrosis, Algodystrophy of the two hips and two cases of bullous cystoid osteitis of phalanges.

Conclusion: The osteo-articular involvement of sarcoidosis is polymorphic, which can reveal the disease or enamel its evolution.

Disclosure of Interests: None declared

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AB1086 ADULT ONSET STILL'S DISEASE: EXPERIENCE OF THE RHEUMATOLOGY DEPARTMENT OF THE UNIVERSITY HOSPITAL OF CASABLANCA

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Background: Adult onset Still's disease (AOSD) is a rare condition characterized by four cardinal signs: fever, arthralgia/arthritis, rash, and neutrophilic leukocytosis. The absence of specific criteria is currently compensated by pathophysiological advances, leading to the introduction of a promising new therapeutic arsenal represented by biotherapies.

Objectives: The aim of this study was to compare the profiles of this disease in our latitudes with data from foreign literature; and to study the most recent data concerning the pathophysiology and treatment of this disease.

Methods: We conducted a retrospective study of hospital files from January 1993 to October 2018. The diagnosis is retained according to Yamaguchi criteria. Analysis was performed using IPSS.

Results: 17 patients were selected. The sex ratio was 0.54, and the average age was 31.5 years. At the time of diagnosis, fever was found in 94% of cases, arthralgia/arthritis in 100% of cases, and rash in 65% of cases. Concerning rheumatic features, the most frequently affected joints were: wrists (87%), knees (73%), shoulders (67%), proximal interphalangeal (62%), elbows and ankles (60%), hips (47%). The involvement of the hands is dominated by the proximal interphalangeal and metacarpophalangeal (45%). Distal interphalangeal involvement is observed in 23% of cases. Cervical spine involvement is noted in 50% of cases. Biologically, 88% of patients had neutrophilic leukocytosis. Ferritinemia was increased in 79% of patients. The glycosylated fraction of ferritin was measured at diagnosis in 47% of patients, of whom 63% had a fraction $\leq 20\%$. Elevated transaminases were found in 47% of cases. Therapeutically, 100% of patients received corticosteroids; 65% methotrexate; and 29% biotherapies (tocilizumab, anakinra, infliximab, adalimumab). The evolutionary profile was exploitable in 13 patients, of whom 10 were in complete remission.

Conclusion: Our data are consistent with those in the literature. Some peculiarities emerge concerning the articular features. From 3 series of literature and ours, totaling 135 cases, it appears that the most frequent locations are: wrist (82%), knees (70%), elbows (46%), ankles (45%), proximal interphalangeal (44%), shoulders (42%) and metacarpophalangeal (42%). The pathogenesis of AOSD seems to lie at the crossroads between auto-inflammatory diseases and lymphohistiocyte activation, resulting from a multifactorial predisposition. The central role of innate immunity, the clinical presentation, and the efficacy of blocking the IL-1 pathway comparable to that observed in “monogenic inflammasomopathies” justify the reclassification of AOSD among polygenic auto-inflammatory syndromes.

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