All the SAPHO patients with spinal involvement were followed up. 30 patients received NSAIDs plus DMARDS/biologics and the symptoms improved. Reexamed 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, enthesitis and spondylodiscitis. The combination of NSAIDS and biologics/DMARDS were helpful to improve the symptoms.

REFERENCES

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Disclosure of Interests: None declared


# 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 protes 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 antibiotic therapy 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


# 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 of them had concomitant FMF diagnosis. One student 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

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Pain</td>
<td>20</td>
<td>66.7</td>
</tr>
<tr>
<td>Fever</td>
<td>23</td>
<td>76.7</td>
</tr>
<tr>
<td>Joint Pain</td>
<td>8</td>
<td>26.7</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>10</td>
<td>33.3</td>
</tr>
<tr>
<td>Muscle Pain</td>
<td>7</td>
<td>23.3</td>
</tr>
<tr>
<td>Erysipelas like</td>
<td>5</td>
<td>16.7</td>
</tr>
</tbody>
</table>

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


# 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 (ASLO, 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 Herpesvirusidae (79 people), M. pneumoniae (15), CL. Pneumoniae (11), Y. enterocolitica (11), Chl. trachomatis (9), H. 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 (OSH 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; CI 1.2–35; p = 0.026) and the presence of conglomerates of nodes (OR 4.8; CI 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), ARV/pyrexia (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