radiographs revealed narrowing of disc spaces in 67.7% of cases and vertebral erosion, vertebral fracture and a paravertebral spindle in 14.51%.

Computed tomography and Spinal magnetic resonance imaging was performed respectively in 62.9% and 70.9% of cases. They showed paravertebral abscess in 66.1%, epiduritis in 56.4%, intra-discal abscess in 3.22%, spinal cord compression in 8.06%, and vertebral osteolysis in 9.67% of cases. Tuberculin Skin Test was performed in 57 (92%) patients and it revealed a positive result in 29 (47%) patients. Disc vertebral biopsy was performed in 45 patients and was contributive in 32.2% of cases revealing caseating granulomas.

A four-drug therapy including isoniazid (INH), rifampin (RMP), pyrazinamide (PZA) and ethambutol (EMB) were administered to 59 (95.16%) patients for the initial two months. Three patients received initial three-drug combination therapy. Following the initial 4-drug regimen, most patients continued to receive a two-drug regimen with RMP and INH for a mean duration of nine months. Over 80% of patients had an immobilisation.

Adverse effects of anti-TB therapy were noted in 17.7% of the patients; [nausea-vomiting: 1.6%, hepatotoxicity: 9.6%, rash: 3.2%, hyperuricemia: 3.2%]. A surgery was needed for 6.4% of patients. Neurological complication occurred in 4 cases, sepsis occurred in 2 other cases and 2 patients were dead.

Conclusion: Spinal tuberculosis results in a significant rate of morbidity due to its insidious course and delayed diagnosis. Early establishment of definitive etiologic diagnosis and appropriate treatment is of paramount importance to prevent development of sequelae.

Disclosure of Interests: None declared

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AB1245 COMPARATIVE ANALYSIS OF SPONTANEOUS INFECTIOUS SPONDYLITIS: PYOGENIC VERSUS BRUCELLA

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Background: Infectious spondylitis is an infectious disease of the spine or paraspinal structures that can be caused by various microorganisms. Without adequate chemotherapy, the outcome can be fatal or result in severe neurologic damage. Therefore, differentiating the etiology of spondylitis is very important.

Objectives: To compare the clinical features, laboratory and radiological aspects, treatment and outcome data of patients diagnosed as brucellar spondylitis (BSP) and pyogenic spondylitis (PSP).

Methods: Retrospective study including 45 (22 BSP and 23 PSP) spondylodiscitis hospitalized in our department between 1999 and 2019. The diagnosis was based on clinical, biological, radiological and bacteriological data.

Results: The patients' mean age was 54 years. There were 31 men (68.8%) and 14 women (31.2%). There was no difference in mean age and sex between the two groups ($p=0.8$ and $p=0.4$; respectively).

The pyogenic group had a relatively higher proportion of Predisposing factors especially diabetes ($p=0.04$). PSD patients suffered an impaired general condition more frequently than BSD patients ($p=0.01$) while BSD patients complained of night sweats more frequently compared to PSD cases ($p=0.026$).

The peak CRP value was higher in the pyogenic group than in the brucella group (87 mg/L and 37 mg/L, respectively, $p=0.027$), whereas the ESR was not significantly different between the groups (71 mm/h and 67 mm/h, respectively, $p=0.7$). We found no statistically significant difference regarding the seat of the spondylitis. Whereas, multifocal involvement was higher in PSD ($p=0.049$). Radiologically, the frequency of prevertebral, paravertebral, epidural, and psoas abscess formations and spinal cord compression was similar in both groups ($p=0.8$).

Surgical interventions and percutaneous sampling and/or abscess drainage were applied more frequently in PSD but with no significant difference ($p<0.23$). Favourable clinical outcome rate was 60% in PSD and it was 72% in BSD group ($p=0.39$).

Conclusion: The clinical and radiological manifestations of spontaneous spondylitis differ based on the causative organism. Pyogenic spondylitis patients tend to have a more severe clinical course and a higher CRP level. However, there was no significant difference regarding the presence of abscess and epiduritis or the occurrence of complications between brucella and pyogenic spondylitis.

Disclosure of Interests: None declared

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AB1246 PREDICTORS OF IMPAIRED QUALITY OF LIFE IN PATIENTS WITH SYSTEMIC DISEASES

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Background: Systemic diseases are heterogeneous diseases that represent one of the leading causes of disability in the industrialized world and can even reduce life. They are associated with high rates of disability, premature mortality, and significant social costs.

Objectives: The objectives of our study were to evaluate the quality of life (QoL) of patients with systemic disease and a comparison between these patients, to search for factors predicting the impairment of quality of life during systemic diseases, and to evaluate work disability of those patients.

Methods: We conducted a cross-sectional study at the Internal Medicine Department of the Farhat Hached Hospital in Sousse between July 2017 and September 2017. We investigated patients with systemic rheumatic, thrust or remission who were present as outpatients or were admitted to the ward during this period. The outcomes were baseline Short Form Health Survey physical (PCS) and mental (MCS) component summary scores QoL. Work disability was evaluated by the work productivity assessment impairment (WPAI) questionnaire. Correlations were calculated by the test t student or Anova factor test and comparison with chi2 test.

Results: Two hundred thirty five patients were included, 183 females and 52 males. The average age was 48,3 years with extremes between 15 and 90 years old. Forty seven per cent of the population had work during the study. The most frequent diseases were: Systemic lupus erythematosus (SLE) in 66 patients, Behçet syndrome in 33 patients and Sjogren primary syndrome (SPS) in 27 patients. Mean PCS were 52.55 ± 17.3 and MCS scores were 47.74 ± 14.8 . For the predictors related to patients: the age ((PCS: $r=-0.250$, $p=0.000$), (MCS: $r=-0.160$, $p=0.014$)), the presence of comorbidities (PCS $p=0.003$) and the low level of education ($p=0.001$) were significantly correlated with impaired QoL, the presence of profession was not significantly correlated with QoL. For the predictors related to the disease; inflammatory myositis influences most the QoL. Pulmonary manifestations (PCS: $p=0.021$, MCS: $p=0.006$) were the most correlated with impaired QoL. Disease index of activity was calculated in 3 diseases and it was significantly correlated with impaired QoL; SLE ((PCS: $r=-0.581$, $p=0.000$), (MCS: $r=-0.494$, $p=0.000$)), SSP ((PCS: $r=-0.500$, $p=0.007$), (MCS: $r=0.522$, $p=0.005$)), Systemic sclerosis ((PCS: $r=0.698$, $p=0.012$), (MCS: $r=0.710$, $p=0.01$)). Work disability was evaluated in working patients: absenteeism was at 31.16 ± 24 , productivity impairment at 48.77 and systemic sclerosis was the most disease predictive of absenteeism and work disability ($p=0.011$).

Conclusion: QoL may be severely impaired in patients suffering from systemic diseases. We studied for the first time the predictors of impaired QoL for all patients followed in our department. Our study concord with literature (1), beside the objective criteria resulting from clinical examination and biological investigations, it seems essential to take into account the individuality of each patient. This measure aims to further humanize medical practice and maintain the quality of life of patients.

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AB1247 RISK FACTORS FOR ADVERSE CLINICAL OUTCOME IN SEPTIC SPONDYLODISCITIS

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Background: Spondylodiscitis is defined as a serious infection of the intervertebral disc and/or adjacent vertebrae. It can lead to neurological sequelae and put life-threatening ones into play.

Objectives: To describe the clinical features and outcomes of septic spondylodiscitis and to identify factors associated with an unfavourable clinical outcome.

Methods: Retrospective study including 107 patients followed up in our department between 1999 and 2019. Clinical, radiological and microbiological data were collected.

We divided patients into two groups: patients with unfavourable clinical outcome (defined as death, drug toxicity, neurological complication, sepsis or persistent pain) (group 1) and patients with a favourable one (Group 2).

Results: We included 107 patients (49 women and 58 men), with a mean age of 55 years old [16 - 86]. The median delay of consultation was 3 months. Predisposing factors were found in 59 patients (55.1%). Inflammatory back pain was seen in 78.5% of cases. Neurologic deficiency was noticed in 16.82% of cases: motor deficit in 1.8% of cases, spinal cord compression in 1.8% of cases and Cauda equina syndrome in 2.8% of cases. An inflammatory biological syndrome was found in 90.6% of cases. The lumbar spine was involved in 55%. The spondylitis was multifocal in 19.6% and multi-stage in 15.8% of cases. CT and Spinal MRI was performed respectively in 60% and 78.8% of cases and showed paravertebral abscess in 63.5%, epiduritis in 54.2%, intra-discal abscess in 4.67%, spinal cord compression 9.3%, and vertebral osteolysis in 8.4% of cases. The causative microorganism was mycobacterium tuberculosis in 59.8%, brucella in 20.56%, and pyogenic germs in 16.8% of cases. 34.5% of patients had an unfavourable clinical outcome: persistent pain was noticed in 18.7%, drug toxicity occurred in 13% of cases, neurological complication occurred in 10.2% of cases, sepsis occurred 3.7% of cases and 3.7% of patients were dead.

In the group1 the frequency of diabetes, impairment of the general state and clinical evidence of neurological impairment at presentation was higher, but with no statistically significant difference. Similarly, the presence of paravertebral abscess, epiduritis or spinal cord compression was slightly more frequent, with no significant difference.

There was no statically significant difference in the age ($p=0.15$), the localisation and the causative microorganism ($p=0.68$).

Conclusion: Spondylodiscitis is a rare but serious condition that leads to significant long-term morbidity. In our study, unfavourable clinical outcomes was found in the presence of diabetes, neurological impairment at presentation and the presence of paravertebral abscess, epiduritis or spinal cord compression in MRI but with no statically significant difference.

Disclosure of Interests: None declared

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AB1248

MALHEUR PROJECT CONFIRMS SPECIFIC CHARACTERISTICS OF MALIGNANCIES IN PATIENTS WITH RHEUMATIC AND MUSCULOSKELETAL DISEASES

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Background: Both rheumatic and musculoskeletal diseases (RMDs) and malignancies are frequent in the population and the probability of simultaneous occurrence in one individual is accordingly high. However, the interrelation of malignancies in patients with RMDs is still a blind spot in rheumatology. Since both disorders present two extremes of a dysregulated immune response, their interdependencies are undoubtedly complex. There is very little reliable data on cancer and relapse risk due to a certain disease entity as well as particular disease modifying therapies.

Objectives: The MalheuR project is a registry-based study that has been initiated at the university hospital Heidelberg, Germany to close this gap.

Methods: In three subregistries, we address the specific situation of patients suffering from concomitant RMD and malignancy (RheuMal registry), paraneoplastic rheumatic disorders due to a malignancy (Para-RheuMa registry) and rheumatic immune-related adverse events (irAE) due to cancer immunotherapy (TRheuma registry). Herein, we present first data from RheuMal registry.

Results: We analyzed 55 patients with concomitant RMDs and malignancies. The mean onset of the RMD was 58.9 years in females ($n=33$) and 54.2 years in males ($n=22$), the mean onset of the malignancy was 59.9 years and 56.3 years respectively. In patients first suffering from a RMD ($n=38$), the average time to malignancy diagnosis was 10.3 years [1-33 years]. Only 13 patients were diagnosed with a malignancy before RMD. 4 were diagnosed for both disorders simultaneously. Solid tumors were present in 54%, hematologic neoplasms in 17%, non-melanoma skin cancer in 21% and melanoma in 8%. 13 patients suffered from more

than one neoplasm with 1 patient showing a secondary neoplasm, 4 patients with recurring skin cancer and 4 with additional benign neoplasms. Out of 6 patients pre-treated with cyclophosphamide, lymphoma, bladder and prostate cancer were diagnosed in one case each. 16 patients were pre-treated with TNFa-inhibitors, 2 cases of melanoma, 4 cases of non-melanoma skin cancer and 2 cases of hematologic neoplasms occurred. Among 7 patients with azathioprine intake, two developed non-melanoma skin cancer, but no melanoma was diagnosed.

A comparison with the German cancer registry of the Robert Koch Institute suggests an earlier onset of gender specific cancers in our patients with mean onset of breast cancer ($n=5$) 5.2 years and prostate cancer ($n=8$) 7.0 years earlier. Furthermore, in males with RMDs melanoma occurred 8.4 years earlier ($n=5$), but squamous cell skin cancer was diagnosed 12.2 years later than in the reference cohort.

Conclusion: Overall, our data show specific characteristics of malignancies in RMD patients suggesting a different cancer epidemiology compared to overall population.

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AB1249

HOSPITAL ADMISSIONS IN PATIENTS WITH CHRONIC RHEUMATIC DISEASES RECEIVING ADALIMUMAB. DESCRIPTIVE STUDY OF A COHORT

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Background: Patients with chronic rheumatic diseases (CRD) treated with biological DMARDs may increase the risk of complications and hospitalizations for serious adverse reactions (SAR). Concomitant treatment with conventional DMARDs and corticosteroids may increase the risk of complications.

Objectives: To describe the prevalence and characteristics of hospital admissions among patients with CRD who are currently receiving Adalimumab (ADL) in a hospital setting.

Methods: Cross-sectional, retrospective, unicentric study. Data obtained from a cross-sectional study to determine levels of ADL and antidrug antibodies in patients currently receiving ADL. We clustered the income in SAR and income not related to bDMARD, describe the clinical and therapeutic data. Groups were compared using Student's t-test and Chi-squared test.

Results: We included 103 patients on ADL treatment, 54.4% (56) men, 45.6% (47) women. The mean age was 54.6 years (SD $\pm$ 13.04). 38.8% diagnosed of rheumatoid arthritis, 42.7% spondyloarthritis, 15.5% psoriatic arthritis and 2.9% juvenile idiopathic arthritis.

33% (34) had at least one income, mean 2.29 SD $\pm$ 2.93 (1-17). Within this group, the mean age was 62.3 years (SD $\pm$ 9.93), the mean time of exposure to ADL was 98.9 months SD $\pm$ 43.68 (3.48-151.49). 44.1% (15) had a standard dose of ADL and 55.9% (19) had a minimum effective dose. 55.9% (19) also received scDMARD and 47.1% (16) oral corticosteroids with a mean dose of prednisone of 3.4 mg (SD $\pm$ 4.6). 78 incomes were produced, 7 (9%) by SAR and 71 (91%) not related to bDMARD. The average income per SAR was 0.50 SD $\pm$ 1.48.

The mean time of exposure to ADL in the group of patients with SAR was 101.97 months SD $\pm$ 33.8, in contrast to patients without hospital admissions that was 65.02 months SD $\pm$ 50.17 ($p < 0.01$). Patients without incomes received a mean daily dose of prednisone of 2.45 mg/day SD $\pm$ 3.71 while those with SAR admission of 4.58 mg/day SD $\pm$ 4.00 ($p < 0.05$).

Conclusion: 33% (34) of patients had at least one admission, they were older (62.3 years SD $\pm$ 9.93) than those without incomes. The mean of income was 2.29 SD $\pm$ 2.93 (1-17). 55.9% of patients also had a scDMARD prescribed and 47.1% oral corticosteroids. 9% of the admissions were by SAR with an average ADL exposure of 101.97 months SD $\pm$ 33.8 compared to patients without hospital admissions, mean 65.02 months SD $\pm$ 50.17 with statistically differences ($p < 0.01$). In addition, differences were found regarding the dose of prednisone, patients with admissions by SAR received 4.58 mg/day SD $\pm$ 4.00 unlike those without incomes who received 2.45 mg/day SD $\pm$ 3.71 ($p > 0.05$).

Weakness of the study is a selection bias since we include the data of patients with current ADL treatment, losing information of those in whom