Infectious spondylodiscitis: tuberculosis versus brucellosis

R. Grasse,1 J. Aounou,1 M. Thabet,1 D. E. H. Abid2,1, F. Ben Fredj,1,3 A. Rezgui2,1, C. Kechrid,1 Sahhoul Hospital Tunisia, Internal Medicine, Sousse, Tunisia; Sahhoul Hospital Tunisia, Sousse, Tunisia

Background: Infectious spondylodiscitis is a serious impairment that can compromise the functional and vital prognosis. The determination of the germ responsible is the key of the treatment.

Objectives: The objective of our work is to describe the epidemiological, clinical and evolutionary profile according to the germ responsible by comparing tuberculosis and brucellar spondylodiscitis.

Methods: This is a retrospective study including 32 cases of spondylodiscitis with specific germs (Mycobacterium tuberculosis and Brucella) collected in an internal medicine department over a period of 18 years (2000-2018).

Results: There were 20 men and 12 women with an M/F ratio of 1.66. The average age of our patients was 50.63 [16-84]. The germ implicated was Koch’s Bacillus in 11 patients (34.38%) and Brucella in 21 patients (65.63%). The mean age for tuberculosis (TB) was 45.18 years versus 53.48 years for brucellosis. Spinal pain was the major symptom in the two groups. The deterioration in general condition was present in 80.95% for the brucellosis group versus 81.82% for the tuberculosis group. Biological inflammatory syndrome was observed in 94.24% of the brucellosis group versus 80.95% for the tuberculosis group.

Conclusion: Infection rachidienne: du germe lent au staphylocoque à l’ancien carriére comme un mycobacterium. Il est décrit un âge moyen de 50.63 ans, avec une prédominance masculine de 1.66. Le diagnostic d’un spondylodiscite a été posé dans 11 cas (34.38%) liés à Brucellosis et dans 21 cas (65.63%) liés à Mycobacterium tuberculosis. L’âge moyen est de 45.18 ans dans le groupe brucelle versus 53.48 ans pour le groupe tuberculose. La douleur lombaire est la manifestation la plus fréquente dans les deux groupes. Le décès est survenu dans 80.95% dans le groupe brucellosis versus 81.82% du groupe tuberculose.

References:

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Tuberculous septic arthritis: clinical features of twelve cases

O. Khaldi, K. Bacoouche, N. El Amri, H. Zieglaoui, E. Bouajina, Farhat Hached Hospital, Rheumatology Department, Susah, Tunisia

Background: Extrapulmonary forms of tuberculous septic arthritis account only for 1% of tuberculous infections. Although TB infection is rare in western countries, the arthropathy is still a major problem in developing countries.

Objectives: Describe clinical features of tuberculous septic arthritis seen by the rheumatologist.

Methods: Retrospective descriptive study, lead in the rheumatology department of Farhat Hached Hospital, including medical files between 1999 and 2020. Data of patients diagnosed with tuberculous arthropathy were analysed.

Results: Twelve patients were diagnosed with tuberculous septic arthritis. Six men and women were enrolled with a sex ratio of 1. The mean age of diagnosis was 47.5±16.16 years. Mean delay of diagnosis was 12.83±15.12 months. A triggering factor like a trauma was described in 8.3% and comorbidities were associated in 16.7% of the cases, mainly diabetes and chronic renal dysfunction. Type of pain was inflammatory in 91.7% of the time. The disease presented as a monoarthritis in 91.7% and an oligoarthritis in 8.3% of the cases. Chronic forms were observed in 91.7% and acute forms in 8.3% of the cases. Transmission was hematological in 60%, directly inoculated in 20% and secondarily disseminated from another site in 20% of the cases. Arthritis affected the knees in 50%, followed by the hips in 33.3% and then the ankles and wrist in 8.3% of the cases each. Fever was noted in 41.7% and general condition was altered in 50% of the patients. Chest radiographs showed the presence of infiltrates or micronodules in 33.3% of the patients. Bone erosions were detected in 66.7% of plain radiographs, while narrowing of the joint was seen in 83.3% and in 33.3% of the cases. Synovial biopsy was performed for all patients. It showed a non specific synovial inflammation in 33% and caseous necrosis in 16.7% of the cases. Common quadri therapy was prescribed for all patients with a mean treatment duration of 11.4±1.37 months. Surgery was performed in only two
cases with an uncontrolled infection under antibiotics. Disseminated tuberculosis accurred in 33.3%, recurrence of the infection in the same site in 16.7% and cases with an uncontrolled infection under antibiotics. Disseminated tuberculosis leading to his death.

**Conclusion:** Tuberculous septic arthritis is difficult to diagnose and should be recalled especially in endemic countries when dealing with chronic monoarthritis. Synovial biopsy is needed most of the time to confirm the diagnosis. Treatment is long and the disease may be complicated with fatal disseminated forms.

**References:**


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**AB0945**

**CONTRIBUTION OF MICROBIOLOGICAL AND ANATOMOPATHOLOGICAL EXAMINATIONS IN THE DIAGNOSIS OF SPONTANEOUS PYOGEN SPONDYLODISISCTIS IN ADULTS**

I. Mahmoud1, M. Moalla1, A. Ben Tekaya1, S. Boudén1, R. Tekaya1, O. Saidane1, L. Abdelmoula1, 1Hospital Charles Nicolle, Rheumatology, Tunisia, U.S.

**Background:** Pyogenic spondylodiscitis (SPD) is a serious infection of an intervertebral disc and/or adjacent vertebrae, that remains a topical problem in rheumatological practice. Early diagnosis and treatment are the only guarantees of a favorable outcome. Clinicians must strive to isolate the responsible bacteria in order to treat the infection, and thus reduce the risk of resistance and complications due to SPD itself, but also to the multiplication of probabilistic treatments.

**Objectives:** Our aim was to study the contribution of the different microbiological and anatomopathological examinations in the diagnosis of pyogenic SPD.

**Methods:** It was a descriptive study in a single rheumatology department. Data were collected retrospectively from observations of patients hospitalized in the past 20 years who had been diagnosed with pyogenic SPD. We excluded cases of tuberculous and brucellar SPD from our study because of their completely different histological and microbiological profiles.

**Results:** Twenty-two cases of pyogenic SPD were collected (14M/ 8F). The mean age of the population was 55.9 years [29,80]. A bacteriological survey including at least one cytobacteriological examination of the urine (CBEU), chest X-rays and blood cultures allowed the identification of the bacteria in 16 cases (73%). The most common site were bacteria was identified was blood culture in 7 cases, skin sample and urine collection in 2 cases each. Diso-vertebral punc- ture and biopsy (DVPB) was performed in 19 patients when there was no bacteria identification and/or when diagnosis of infectious SPD persisted doubtful. On histopathological examination, were described: an infiltrate and/or inflammatory changes without specificity signs in 7 patients and an appearance of chronic pyogenic SPD very likely in 12 patients. Bacteriological study of DVPB fluid or paravertebral abscesses sample helped to isolate bacteria in 4 patients. DVPB or abscesses puncture were contributing by histological and/or bacteriological examination in 12 patients (63%). Infecting bacteria was identified in 14 patients (64%). Gram-negative bacilli (GNB) and staphylococcus aureus were the most frequent germs (7 cases each) including 2 cases of co-infection. GNBs were represented by: Escherichia Coli and Enterobacter Cloacae in 2 cases each, Proteus Mirabalis, Serratia Marcescens and Klebsiella oxytoca in 1 case each. Clostridium clostridiotforme and Lactococcus cremoris were isolated in 1 case each. For patients whose etiological investigation remained negative, SPD diagnosis was retained based on imaging (MRI) guided by anamnestic, clinico-biological and histopathological arguments.

**Conclusion:** SPD is a rare condition that needs to be treated rapidly. Once the diagnosis is suspected, bacteria must be isolated before starting any antibiotic therapy. Simple and non-invasive exams as blood cultures, CBEU and chest rays, should be undertaken first. In fact, these simple exams allowed a germ identification in 73% cases in our study. If doubt persist, DVPB could be contributive to the diagnosis.

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**AB0947**

**RECIPIROCAL IMPACT OF FIBROMYALGIA ON DISEASE CHARACTERISTICS AND PHYSICAL AND PSYCHOLOGICAL DOMAINS IN SJOGREN SYNDROME: CROSS SECTIONAL OBSERVATIONAL STUDY.**

A. Capacci1, P. Rubortone1, V. Varriano1, A. Paglioncio1, S. Perniola1, M. F. Gigante1, B. Tolusso1, S. Aliverinni2, E. Gremese2, Fondazione Policlinico Universitario A. Gemelli IRCCS, Rome, Italy; 2Fondazione Universitaria A. Gemelli IRCCS - Università Cattolica del Sacro Cuore, Rome, Italy

**Background:** Sjogren Syndrome (SS) is an autoimmune exocrinopathy, resulting mainly in ocular and oral dryness, with approximately half of patients displaying symptoms from different organ systems, further adding to the heterogeneous clinical phenotype of the disease. Fatigue and pain are common systemic symp- toms in patients with primary SS and fibromyalgia is a frequent condition associated with chronic diseases.

**Objectives:** The aim of the study was to evaluate the impact of concomitant fibromyalgia in patients with Sjogren Syndrome in terms of clinical features and disease activity.

**Methods:** 50 patients with Sjogren Syndrome were enrolled in the study (100% female, age: 53.7 ± 13.2 years and disease duration: 8.7 ± 5.3 years), 25(50.0%) with concomitant fibromyalgia (SS/Fibro-group) and 25(50.0%) without (SS-group). 36 patients with primary fibromyalgia (Fibro-group) were included as control group. At study entry, demographic, educational, life-style and clinical parameters were recorded for each patient. SS was diagnosed according to the American College of Rheumatology (ACR) classification criteria (1) and fibromyalgia was diagnosed according to criteria for fibromyalgia defined by ACR (2). Moreover, each patient with fibromyalgia, with and without concomitant SS, was asked to fill a self-reported questionnaire to assess the impact of Fibromyalgia on multiple physical and psychological domains (Ravallion & FR). Results: Stratifying the study cohorts based on the demographic and life-style characteristics, no significant differences were found comparing SS-group, Fibro-group and SS/Fibro-group. However, considering the different organ involvement,