cases with an uncontrolled infection under antibiotics. Disseminated tuberculosis accured in 33.3%, recurrence of the infection in the same site in 16.7% and extension to another articular localisation in 25% of the cases. One patient had a tuberculous meningoencephalitis 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 PYOGENIC SPONDYLODISCITIS IN ADULTS

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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 start the treatment, 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 anatomo-pathological examinations in the diagnosis of pyogenic SPD.

Methods: We retrospectively reviewed the clinical data of 19 patients 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. Disce-vertebral puncture and biopsy (DVPB) was performed in 19 patients when there was no bacteriological determination 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 histopathological examination was performed 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 Mirabilis, Serratia Marcescens and Klebsiella oxytoca in 1 case each. Clostridium Clostridiotoforme and Lactococcus were isolated in 1 case each. For patients whose etiological investigation remained negative, SPD diagnosis was retained based on imaging (MRI) guided by anamnesic, clinico-biological and histopathological arguments.

Conclusion: SPD is a rare condition that needs to be treated quickly. 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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Pain in rheumatic diseases, including fibromyalgia

AB0947 RECIPROCAL IMPACT OF FIBROMYALGIA ON DISEASE CHARACTERISTICS AND PHYSICAL AND PSYCHOLOGICAL DOMAINS IN SJOGREN SYNDROME: CROSS SECTIONAL OBSERVATIONAL STUDY

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Background: Sjogren Syndrome (SS) is an autoimmune exocrinopathy, resulting mainly in ocular and oral dryness, with approximately half of patients displaying symptoms from different organs systems, further adding to the heterogeneous clinical phenotype of the disease. Fatigue and pain are common systemic symptoms 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 ± 1.2 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 (Italian-FIQR).

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,
SS/Fibro-group were more likely reporting arthralgia symptoms (100.0%) than SS-group (76.0% p=0.02), despite similar clinical evidence of arthritis-synovitis among the two groups (12.0% in both groups respectively, p=1.00). Moreover, SS/Fibro-group showed significantly lower ESSDAI score (2.8 ± 1.7) and higher ESSPRI score (7.0 ± 0.9) compared to SS-group (ESSDAI: 7.5 ± 3.7 p<0.001 and ESSPRI: 5.2 ± 1.4, p<0.001 respectively). Finally, analyzing the differential distribution of individual scores of physical and psychological domains of the Italian-FQRQ-Nomina, SS/Fibro-group did not differ compared to Fibro-group (p>0.05 for all the 21 questions included).

Conclusion: SS is affected by concomitant fibromyalgia in terms of subjective-dependent parameters (i.e. joint complaints) however the concomitant SS does not affect the impact of fibromyalgia on physical and psychological domains, even if disease activity is higher in SS patients without fibromyalgia.

References:

Disclosure of Interests: Annamaria Paglionico: None declared, Pietro Rubortone:

## AB0948

TIME TO CONSIDER HYPERMOBILITY AS A CAUSE OF SYMPTOMS IN PATIENTS PRESENTING TO EARLY ARTHRITIS CLINICS: A CHARACTERISATION OF 279 PATIENTS

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Background: Joint hypermobility is a common, although largely ignored physical sign. It is often asymptomatic but can be associated with significant musculoskeletal symptoms. Joint hypermobility may also be a feature of an underlying genetic disorder and patients may present with arthralgia, recurrent soft tissue injuries and intermittent joint swelling due to mechanical instability and poor proprioception. At University College Hospital London, we run a national service for the diagnosis and management of patients with hypermobility related disorders including hypermobility spectrum disorders, Ehlers-Danlos syndromes and Marfan syndrome. Over the years we observed that a significant number of our patients had been referred to the early arthritis clinics years prior to the recognition of their hypermobility. For example, one patient with a vascular type of Ehlers-Danlos syndrome EDS (confirmed COL3A mutation) presented to 3 different hospitals over a 5-year period, with positive inflammatory arthritis prior to the EDS diagnosis. Several studies have shown that a significant proportion of patients attending early arthritis clinics do not have inflammatory rheumatic diseases. In our experience, heritable disorders of connective tissue and hypermobility spectrum disorders are often overlooked and should be included in the differential diagnosis in patients seen in the early arthritis clinics.

Objectives: We aimed to audit the outcome of patients who were seen in the early arthritis clinics focusing on those who were not found to have inflammatory rheumatic diseases and to explore if joint hypermobility was considered as a possible cause of patient's symptoms.

Methods: A retrospective analysis of medical records was conducted of patients attending the early arthritis clinics at University College London Hospital between May 2018 and December 2019.

Results: 279 patients (96 males, 189 females) were seen in the early arthritis clinics with a mean age of 48 (range 19-91). 131 patients (47%) did not have inflammatory rheumatic diseases. Sixty-three of these patients (48%) were not given any diagnosis and joint hypermobility was not assessed during the appointment. Eleven patients (8%) had features of hypermobility, 11 patients (8%) were diagnosed with fibromyalgia, 20 patients (15%) received a diagnosis of osteoarthritis, and 27 patients (21%) were given other diagnoses including tendinitis and soft tissue pathology.

Conclusion: Almost 50% of patients who were seen in the early arthritis clinics did not have inflammatory rheumatic diseases and 21% of patients were discharged without a clear diagnosis. In these patients, hypermobility was not assessed and this is consistent with our observation. In our experience recognizing joint hypermobility as a cause of arthralgia and intermittent joint swelling usually reassures patients and motivates them to follow appropriate treatment protocols including physiotherapy and occupational therapy thus allowing a more efficient utilization of early arthritis clinic resources towards those with true inflammatory rheumatic diseases. Going forward, we have planned to embed a cognisant attitude towards hypermobility within the relevant clinics to ensure that patients who do not have inflammatory arthritis are assessed for hypermobility and directed towards appropriate management.

References:

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