cases with an uncontrolled infection under antibiotics. Disseminated tuberculosis occurred 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 meningoenzephalitis 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:

- [1] Foocharoen C, Nanagara R, Foocharoen T, Moosikapun P, Suwannaroj S, Mahakkanukrauh A. Clinical features of tuberculous septic arthritis in Khon Kaen, Thailand: a 10-year retrospective study. *Southeast Asian J Trop Med Public Health*. nov 2010;41(6):1438-46.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.5664

AB0945

CONTRIBUTION OF MICROBIOLOGICAL AND ANATOMOPATHOLOGICAL EXAMINATIONS IN THE DIAGNOSIS OF SPONTANEOUS PYOGENIC SPONDYLODISCITIS IN ADULTS

I. Mahmoud¹, M. Moalla¹, A. Ben Tekaya¹, S. Bouden¹, R. Tekaya¹, O. Saidane¹, L. Abdelmoula¹. ¹Hospital Charles Nicolle, Rheumatology, TUNIS, Tunisia

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 adapt 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 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 have 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 where bacteria was identified was blood culture in 7 cases, skin sample and urine collection in 2 cases each. Disco-vertebral puncture 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 Mirabilis*, *Serratia Marcescens* and *Klebsiella oxytoca* in 1 case each. *Clostridium clostridioforme* 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, CBUE and chest rays, should be undertaken first. In fact, these simple exams allowed a germ identification in 73% cases in our study. If doubt persists, DVPB could be contributive to the diagnosis.

References: None

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.6272

AB0946

PARTICULARITY OF MULTIFOCAL INFECTIOUS SPONDYLODISCITIS

S. Miladi¹, K. Saadaoui¹, A. Fazaa¹, S. Mariem¹, K. Ouenniche¹, L. Souabni¹, S. Kassab¹, S. Chkili¹, L. Zakraoui¹, A. Laatar¹. ¹Mongi Slim Hospital, Rheumatology, Marsa, Tunisia

Background: Infectious spondylodiscitis is an infection of the intervertebral disc with damage to the vertebrae. Multiple stage involvement may lead to serious complications. Better understanding of this infection is mandatory for optimal management.

Objectives: The objective of our study was to describe the clinical, biological aspects and the course of this disease.

Methods: This is a retrospective study including cases of infectious spondylodiscitis collected in a single rheumatology center between 2002 and 2018. Multifocal spondylodiscitis was defined as an involvement of 2 or more disc levels. Clinical, biological and evolution of this disease were reported.

Results: Among the 52 cases of infectious spondylodiscitis collected, thirteen patients had multi-stage involvement of the spine. The sex ratio M/F in this group = 0.44 with an average age of 52 ± 14.32 years [31 – 76 years]. Diabetes mellitus was observed in 3 patients, chronic renal failure in one case and immunosuppressive therapy in one case. At the moment of the diagnosis, inflammatory back pain was present in all patients, fever was noted in 8 patients (61.5%), neurological deficit in 2 patients (15.4%) and weight loss in 4 cases (30.8%). The diagnosis time delay was 22 ± 15.9 weeks [2 – 60 weeks]. The mean CRP was 70.16 mg / L ± 55.5 [3.4 - 178] and the ESR was on average 79 mm ± 31.28 [6 - 125]. Diagnosis was confirmed by MRI in all cases. A prevertebral abscess was observed in 7 cases (13.5%), an epiduritis in 5 patients (38.5%) and a psoas abscess in two cases (15.2%). The cervical spine was affected in 3 cases, the dorsal spine as well as the lumbar spine were affected in 12 cases. The involvement of 2 vertebral sites was the most frequent with 7 cases. A maximum of 5 sites was noted in 3 cases. The thoracolumbar spine was the most affected with 11 cases (84.6%), the cervico-thoraco-lumbar involvement was found in only one case (7.7%). The bacteriological diagnosis was done by the disco-vertebral biopsy in 6 cases (46.2%), the brucellar serology in 3 cases (26.1%) and a strong presumption of tuberculosis (with positive IDR or Quantiferon) in 4 cases (30.8%). Mycobacterium tuberculosis was isolated in 8 patients (61.5%), brucella melitensis in 3 patients (23.1%) and staphylococcus aureus was found in 2 cases (15.4%). The outcome was favorable in all patients with appropriate antibiotic therapy after an average follow-up of 10.9 months ± 2.19.

Conclusion: Multifocal infectious spondylodiscitis is a serious disorder which mainly affects immunocompromised patients and the specific germs are the most incriminated.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.6172

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.

A. Capacci¹, P. Rubortone¹, V. Varriano¹, A. Paglionico¹, S. Perniola¹, M. R. Gigante¹, B. Toluoso¹, S. Alivernini², E. Gremese². ¹Fondazione Policlinico Universitario A. Gemelli IRCCS, Rome, Italy; ²Fondazione Policlinico Universitario 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 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 ± 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 (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,