Conclusion: In this post hoc analysis, LOR-treated subjects reported greater improvements in PRO threshold responses versus PBO from Week 12 through Week 24. LOR demonstrated significantly higher odds of achieving and maintaining improvements in PROs at 30% and 50% thresholds. Phase 3 studies of 0.07 mg LOR are ongoing.

References:

- [1] Deshmukh V, et al. *Osteoarthritis Cartilage*. 2019.

Figure 1. Percentage of Phase 2b trial subjects in the LOR and placebo (PBO) groups responding to treatment with 30%, 50%, or 70% threshold responses over baseline at Week 12. The Pain NRS and WOMAC Function outcomes are shown. * $P < 0.05$, ** $P < 0.01$, *** $P < 0.001$ vs. PBO by logistic regression using the Full Analysis Set and non-responder imputation.

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Infection-related rheumatic diseases

FRI0431

PROFILE OF INFECTIOUS SPONDYLODISCITIS ACCORDING TO THE SITE: UNIFOCAL VERSUS MULTIFOCAL

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Background: Infectious spondylodiscitis is a therapeutic emergency and is a current problem. It can affect the different levels of the spine. Multifocal forms, touching several floors, however remain rare.

Objectives: To compare the clinical, biological, radiological and therapeutic aspects of unifocal versus multifocal spondylodiscitis.

Methods: This is a retrospective study of 113 patients admitted to our service over a period of 20 years [1998-2018]. The diagnosis of spondylodiscitis was made on the basis of clinical, biological, radiological and bacteriological data. We have divided our population into two groups: unifocal and multifocal spondylodiscitis.

Results: Spondylodiscitis was more frequently unifocal (75.2%) than multifocal (24.8%). The average age of the patients was 55.8 years. There were 62 men and 51 women. There was no difference in age and sex between the two groups ($p=0.5$ and $p=0.8$, respectively).

Diabetes was more frequent in the group of multifocal spondylodiscitis but with no statistically significant difference ($p=0.4$). No statistically significant difference between the two groups regarding the start mode ($p=0.7$), the schedule ($p=0.3$), the presence of neurological signs ($p=0.7$), fever ($p=0.2$), impaired general condition ($p=0.6$) and biological inflammatory syndrome ($p=0.6$).

Cervical and dorsal spine involvement was more common in multifocal spondylodiscitis ($p=0.02$ and $p=0.01$; respectively). There were 11 spondylodiscitis involving 2 floors (cervical and dorsal: 2 cases, cervical and lumbar: 3 cases, dorsal and lumbar: 6 cases) and 3 spondylodiscitis involving 3 floors.

Radiologically, the presence of vertebral fracture and involvement of the posterior arch was more frequent during the multifocal form ($p=0.03$ and $p=0.001$; respectively). The frequency of para-vertebral abscesses, epiduritis and the presence of spinal cord compression were similar in the two groups ($p=0.6$; $p=0.7$ and $p=0.2$, respectively).

Tuberculosis was more frequent during the multifocal form ($p=0.05$) and brucellosis during the unifocal form ($p=0.03$). Disco-vertebral biopsy was performed in 79 cases. It was more often contributory during multifocal spondylodiscitis ($p=0.03$).

The occurrence of immediate complications was more frequent in multifocal spondylodiscitis but with no statistically significant difference ($p=0.2$).

Conclusion: Multifocal spondylodiscitis is seen mainly in immunocompromised subjects. Our study found that diabetes is the most common factor in immunosuppression. Note also the predominance of involvement of the posterior elements, tuberculous origin and immediate complications.

Disclosure of Interests: None declared

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INTEREST OF IMAGING IN THE DIAGNOSIS OF INFECTIOUS SPONDYLODISCITIS (ABOUT 113 CASES)

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Background: Infectious spondylodiscitis is a diagnosis and therapeutic emergency. Its clinical presentation can be insidious and standard radiographs can be falsely reassuring. This explains the interest of cross-sectional imaging and more particularly magnetic resonance imaging (MRI).

Objectives: To analyse the contribution of imaging in the diagnosis of infectious spondylodiscitis.

Methods: These are 113 cases of spondylodiscitis collected in a rheumatology department over a period of 20 years [1998-2018]. The diagnosis is made on the basis of clinical, biological, radiological and bacteriological data.

Results: Our population was divided into 62 men (54.9%) and 51 women (45.1%) ($p=0.8$) with an average age of 55 years [16-86]. Predisposing factors were found in 52.2% of cases: diabetes (23%), neoplasia (2.7%), hepatopathy (5.3%), long-term corticosteroid therapy (1.8%), recent surgery (3.5%), history of tuberculosis (2.7%) and consumption of unpasteurized dairy products (28.3%).

The approximate time between onset of symptoms and diagnosis ranged from 0.23 to 24 months (median 3 months). Impaired general condition was observed in 81% of the cases and fever in 34.5% of the cases. Radiculargia was found in 46% of the cases and a neurological deficit was noted in 16% of the cases. Biological inflammatory syndrome was found in 91.2% of the cases.

Standard radiographs of the spine were abnormal in 85% of cases, showing disc space narrowing (72%), irregularity of the vertebral plates (35.5%), erosions (13.1%) and para-vertebral spindle (4.7%). CT and spinal MRI were performed respectively in 57.5% and 70.8% of cases and revealed: erosions (46.2%), mirrored geodes (16.9%), para-vertebral abscess (57.5%), epiduritis (71.3%) and spinal compression (26.3%). The lumbar spine was the most affected (55.8%), followed by the dorsal spine (30.1%) and the cervical spine (8.8%). The infectious spondylodiscitis was multifocal in 24.8% and multi-stage in 12.4% of cases.

A disco-vertebral biopsy was performed in 70% of cases and was contributory in 44.3% of cases. The causative organism was tuberculosis in 55.8% of cases, brucellosis in 12.2% of cases and pyogenic germs in 23% of cases.

Conclusion: Imaging plays an important role in the diagnosis of spondylodiscitis. MRI is considered the key examination, capable of mapping injuries and detecting potentially serious neurological complications. The importance of imaging the entire spine to detect multifocal forms should also be emphasized.

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FRI0433

HAS THE PROFILE OF INFECTIOUS SPONDYLODISCITIS CHANGED IN 20 YEARS?

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Background: Infectious spondylodiscitis represents 2 to 4% of osteoarticular infections. Their incidence is constantly increasing. Early microbiological diagnosis and targeted multidisciplinary management are the main prognostic factors for infectious spondylodiscitis.