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FRI0447

FIRST COMPREHENSIVE LONG-TERM ASSESSMENT OF MUSCULOSKELETAL CONSEQUENCES AMONG EBOLA SURVIVORS

Y. M. Pers¹, A. Dubois², T. A. Barry³, M. D. Sall³, L. March⁴, M. S. Sow³, A. K. Keita⁵, B. Taverne⁵, J. F. Etard⁵, A. Toure⁶, M. Barry⁷, E. Delaporte⁵ on behalf of Postebogui Study Group. ¹CHU Montpellier, Montpellier, France; ²Rheumatologie libérale, Brive, France; ³Donka University National Hospital, Conakry, Guinea; ⁴LPED UMR 151, Aix Marseille Univ, IRD, LPED, Marseille, France; ⁵TransVIHMI INSERM, IRD, University of Montpellier, Montpellier, France; ⁶Conakry University, Conakry, Guinea; ⁷University Gamal Nasser, Conakry, Guinea

Background: The tremendous size of the 2013-2016 West African outbreak of Ebola virus disease (EVD) resulted in a sizeable population of survivors, many reporting short-term sequelae such as arthralgia and myalgia.

Objectives: We aimed to report a detailed and long-term description of patients' musculoskeletal (MS) symptoms.

Methods: We performed a cross-sectional study following systematic rheumatological screening of patients included in the Postebogui cohort (Conakry district). We used regression models to establish the magnitude of EVD as a risk factor for developing chronic MS pain by comparison with a control cohort and to establish risk factors for developing MS pain among survivors.

Results: The study included 313 patients (55.6% female), with a median age of 28.2 years (IQR 21-37), and a median time from ETC discharge to rheumatological visit of 26.2 months (IQR 23-30). Chronic MS pain was reported in 216 (69%) patients, and was predominantly mechanical (48%). Enthesis and painful peripheral joints were largely involved (91%) with symmetrical distribution. Previous Ebola infection was a major risk factor for chronic MS pain (aOR, 6.662 [95% CI, 4.522-9.921]). Among survivors, increasing age (OR 1.14, 95% CI 1.08-1.22) and female gender (OR 3.58, 95% CI 1.22-11.80) were both associated with persistent MS pain, while myalgia experienced during the acute phase of EVD appeared protective (OR 0.14, 95% CI 0.04-0.42).

Conclusion: Our study provides the most accurate long-term description of MS disorders among Ebola survivors. Joint and muscle pain sequelae are frequent and require specialized care.

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FRI0448

FOUR CASES OF SYPHILIS MIMICKING RHEUMATOLOGICAL CONDITIONS PRESENTING TO THE GENERAL RHEUMATOLOGY SERVICE AT ST GEORGES HOSPITAL, LONDON, UK IN 2018-2019

S. Qureshi¹, K. Moss¹, A. Ezeonyej¹, V. Sandhu¹. ¹St George's Hospital, London, United Kingdom

Background: Sir William Osler once wrote: "He, who knows syphilis, knows medicine"

Whilst the Tuskegee Syphilis trials live in infamy, the advent of successful penicillin treatment and sexual health education resulted in the lowest recorded incidence ever in 2001¹.

Unfortunately, cases of syphilis have nearly tripled in the past decade (from 2,847 in 2009 to 7,541 in 2018 in the UK)¹. WHO now estimates the global median prevalence of Syphilis, among men who have sex with men, is 6%². The current cohort of clinicians will therefore have limited clinical experience of Syphilis, which can often mimic rheumatic conditions. We present the clinical experience of a tertiary teaching centre hospital.

Objectives: To identify the scope of clinical cases, with a diagnosis of Syphilis, during 2018-2019 at St Georges University Hospital, London, UK.

Methods: Clinical cases were identified by health professionals and a retrospective review of medical records was undertaken.

Results: There were 4 cases identified during 2018-19.

Case 1: The patient was diagnosed with bilateral uveitis secondary to primary syphilis, and immunosuppression may have contributed to this.

Case 2: The rash developed after the initial presentation and an extended infection screen was performed.

Case 3: The patient had a 6 month duration of symptoms and had had a negative sexual health screen 1 year prior to presentation.

Case 4: The patient had no features of extra pulmonary sarcoidosis and an infectious screen was undertaken.

All 4 cases were referred to the Infectious Disease Unit for treatment. 3 patients received standard treatment with Penicillin, and 1 patient received an oral course of Doxycycline, due to a penicillin allergy.

2 of the 4 cases had complete resolution of symptoms, and 2 of the cases had only partial resolution of symptoms at the time of publication.

Conclusion: Syphilis can present with an inflammatory arthritis, PMR and GCA -type symptoms, ocular inflammation, neurological disturbance and rashes that can mimic autoimmune conditions.

Our cases highlight the increasing incidence, as well as the risk of reactivation following immunosuppression. Current practice does not advise routine testing for syphilis prior to initiation of immunosuppressive therapy. However the rising incidence should prompt careful evaluation, and detailed sexual history, particularly in high risk groups. The diagnostic test interpretation and treatment requires close collaboration with Infectious Diseases Specialists.

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FRI0449

MANAGEMENT AND OUTCOME OF SEPTIC ARTHRITIS OF NATIVE JOINT: A NATIONWIDE SURVEY

P. Richebé¹, S. Godot², G. Coiffier³, P. Guggenbuhl³, D. Mulleman⁴, M. Couderc⁵, E. Dernis⁶, V. Deprez⁷, C. Salliot⁸, S. Urien⁹, R. Brault¹⁰, A. Ruyssen-Witrand¹¹, E. Hoppe¹², J. E. Gottenberg¹³, C. Roux¹⁴, S. Ottaviani¹⁵, M. Breban¹⁶, M. Beaufre¹⁶, A. Michaut¹⁷, L. Pauvele¹⁸, C. Darrieutort¹⁹, D. Wendling²⁰, P. Coquerelle²¹, G. Bar³, E. Gervais¹⁰, V. Goeb⁷, M. Ardizzone²², E. Pertuiset²³, S. Derolez¹, J. M. Ziza², R. M. Flipo²⁴, R. Seror¹ on behalf of Osteoarticular Infection Study Group. ¹Kremlin-Bicêtre University Hospital, Le Kremlin-Bicêtre, France; ²Diaconesses Croix Saint-Simon Hospital, Paris, France; ³Rennes University Hospital, Rennes, France; ⁴Tours University Hospital, Tours, France; ⁵Gabriel-Montpied University Hospital, Clermont-Ferrand, France; ⁶Le Mans Hospital, Le Mans, France; ⁷Amiens Nord University Hospital, Amiens, France; ⁸Orléans Hospital, Orléans, France; ⁹Cochin University Hospital, Paris, France; ¹⁰Poitiers University Hospital, Poitiers, France; ¹¹Toulouse University Hospital, Toulouse, France; ¹²Angers University Hospital, Angers, France; ¹³Strasbourg University Hospital, Strasbourg, France; ¹⁴Nice University Hospital, Nice, France; ¹⁵Bichat University Hospital, Paris, France; ¹⁶Ambroise-Paré Hospital, Boulogne-Billancourt, France; ¹⁷La Roche-sur-Yon Hospital, La Roche-sur-Yon, France; ¹⁸Maison Blanche Hospital, Reims, France; ¹⁹Hôtel-Dieu University Hospital, Nantes, France; ²⁰Besançon University

Patient	Age	Sex	Past Medical History	Symptomatology	Risk Factors	Presumed Diagnosis	Serology
1	69	Male	Hypertension GCA	Bilateral visual loss, rash	MSM Prednisolone Tocilizumab	GCA-related visual loss	RPR 1:64 TPPA 1: 10248
2	46	Female	Nil	Joint pain and swelling, rash	Hepatitis B Core Antibody positive MSM	Undifferentiated Inflammatory Arthritis Primary Syphilis	RPR 1: 16
3	40	Male	Nil	Joint pain, alopecia, uveitis and rash, weight loss			RPR 1: 16 TPPA 1: 10248
4	86	Female	Pulmonary Sarcoidosis, Squamous cell carcinoma of left maxillary sinus	Lower motor neuron facial nerve palsy	Prednisolone	Sarcoidosis	RPR 1:4 TPPA 1:80

GCA: Giant cell arteritis, MSM: Men who have sex with men, RPR: rapid plasma regain, TPPA: Treponema pallidum particle agglutination assay