listed (mainly with bDMARDs and tsDMARDs), followed by influenza. Common non-viral causes of infection were candida and tinea species. Variable or absent reporting was noted for opportunistic infections (e.g. tuberculosis and fungi) and certain high-prevalence viruses e.g. Epstein-Barr.

Conclusion: The SmPC literature reports differences in infection risk, by site and pathogen, between immune-modulatory drugs. The findings can be used to visualise differences and aid treatment decisions. However, some of the patterns we have shown lack face-validity to clinicians familiar with real-world safety data. The data fail to capture risk of rare infections, are likely skewed by trial selection criteria, varying number of trials per drug and quirks of individual study-reporting methodologies. The findings highlight the need for robust post-marketing pharmacovigilance studies.

REFERENCES:

- [1] A Guideline on Summary of Product Characteristics Module 1.3. 2008.

Drug & target		ENT	GI	LRTI	SKIN/SOFT TISSUE	URTI	UTI
Conventional synthetic drugs	Cladribine						
	Mycophenolate mofetil						
	Teriflunomide						
Targeted synthetic drugs	Janus kinase						
	Baricitinib						
	Fingolimod						
	Sphingosine 1-phosphate receptor						
	Fingolimod						
Biologic drugs	TNF α						
	Adalimumab						
	Etanercept						
	Golimumab						
	Infliximab						
	IL-6						
	Sarilumab						
	Tocilizumab						
	IL-17						
	Ixekizumab						
	Secukinumab						
	IL-12/23						
	Ustekinumab						
	IL-23						
	Guselkumab						
Cell-targeted	Complement C5						
	Eculizumab						
	Ravulizumab						
	Other cytokine/enzyme target						
	Anakinra						
	Canakinumab						
	Mitoxantrone						
	Abatacept						
	Alemtuzumab						
	Belimumab						

Figure 1: Summary of common sites of infection for immune-modulatory drugs.

Key: Very common (red dot); Common (orange dot); Uncommon (yellow dot); Rare (green dot); Blank: no information available

Disclosure of Interests: None declared.

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AB0650

SCREENING TESTS FOR LATENT TUBERCULOSIS OF CANDIDATES TO BIOLOGIC THERAPY: DATA FROM THE TUNISIAN BINAR REGISTRY

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Background: The screening and treatment of latent tuberculosis infection (LTBI) is required before starting biologic therapy. Tuberculin skin test (TST) and interferon γ gamma release assay (IGRA) are the two commonly used tests.

Objectives: The aim of our study was to analyze data from the Biological National Registry BINAR between 2016 and 2020 in order to compare the diagnostic value of TST and IGRA tests.

Methods: We collected data of patients diagnosed with LTBI (having had a TST and/or IGRA before receiving any biotherapy) from the BINAR registry (a National Tunisian registry of patients with inflammatory rheumatic diseases under biologic therapy since less than two years from the inclusion date).

Results: From a total of 298 patients included in our study, 199 patients (66.8%) were screened by TST and 159 patients were screened (53.4%) by IGRA.

Thirty-four patients (11.4%) had a positive TST and 27 patients (9.1%) had a positive IGRA test.

Three patients having negative TST and two having negative IGRA developed tuberculosis.

There was no significant difference in our study between these two tests for LTBI diagnosis. The reactivation of tuberculosis can occur even when LTBI screening is negative using TST and IGRA tests.

Conclusion: Our results show that the predictive diagnostic value for these two tests is the same. It would be more interesting to practice one of those tests prior to biotherapy.

Disclosure of Interests: None declared.

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COVID-19

AB0651

CASE-REPORT: ORGANIZING PNEUMONIA IN A PREGNANT WOMAN WITH RHEUMATOID ARTHRITIS DURING COVID-19 PANDEMIC

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Conclusion: Case-report: Organizing pneumonia in a pregnant woman with rheumatoid arthritis during Covid-19 pandemic

CORNILLIE Alexia, GRIVEGNE Camille, CHU Charleroi Marie-Curie

Introduction

Rheumatoid arthritis (RA) is a systemic inflammatory disease characterized by destructive polyarthritis and extra-articular organ involvement. Lungs are one of the most commonly affected organ in RA, and the lung involvement in RA results in a various clinical features including interstitial lung disease (ILD) and organizing pneumonia (OP).

OP is a histologic term characterized by the presence of buds of granulation tissue in bronchioles and alveoli. OP can be either idiopathic (cryptogenic organizing pneumonia) or secondary to underlying disease such as infection, drugs or connective tissue disease including RA.

Lung biopsy is usually recommended for the diagnosis, but the following criteria fulfilled by patients can lead to the diagnosis: (1) specific radiological manifestations (nonsegmental randomized consolidation with/without ground glass opacities in chest CT), (2) no causative infectious agent, (3) no response to antibiotics and (4) good response to corticosteroid therapy.

We describe here the case of organized pneumonia discovered in a pregnant woman with known rheumatoid arthritis during COVID-19 pandemic.

Case description

A 39-year old moroccan woman, gravida 4, para 1, was admitted during COVID-19 pandemic at 30 weeks' gestation to maternity hospital with a 1-week history of cough, dyspnea and fever. Her medical history included rheumatoid arthritis and gestational diabetes. She was treated with 5mg of prednisolone daily for her RA. Blood sample showed white blood cell count and C reactive protein at a level of 6860/mm³ and 42mg/L respectively. Chest CT performed at her admission revealed diffuse irregular nodular condensations associated with ground glass infiltrates and a right lower lobe parenchymal condensation with airbronchogram in favor of superinfection. Given circumstances, she was tested twice for SARS-Cov-2 48 hours apart by PCR on nasopharyngeal sample and results came back negative. She was treated empirically with ceftriaxone and azithromycin during the first week and described an improvement in her clinical condition but symptoms reappeared 4 days after stopping treatment. During the 2 following months, until the delivery, the patient remained subpyretic with a nonproductive cough and moderate dyspnea. 5 days after the delivery, due