AB0782  MONOA RT HRITIS: PROBABLE OUTCOMES
M. Osipyan1, M. Efraimidou1, V. Vardanyan2, K. Ginosyan1. 1st University Hospital Complex after M. Heratsi, Rheumatology, Yerevan, Armenia; 2Miakalyan Institute of Surgery, Rheumatology, Yerevan, Armenia

Background: Numerous joint disorders initially produce swelling in a single joint and new onset monoarthritis will probably further lead to the involvement of other joint groups and development of extraarticular manifestations. It is essential to take a proper diagnostic approach for organizing appropriate treatment and lowering possibility of disease progression.

Objectives: The aim of this study was to investigate joint distribution, determine rheumatological diseases of patients with acute monoarthritis and reveal the development of further systemic manifestations.

Methods: 100 patients (age 18-75 years) with clinically apparent monoarthritis of less than 6 weeks duration were included in the study. Criteria of exclusion were infection, trauma and crystal induced arthritis. Joint distribution, presence of systemic manifestations and development of chronic inflammatory rheumatic disease were evaluated. Presence of arthritis was proved with help of ultrasound examination. Complete blood count, ESR, CRP, RF, anti-CCP, HLAB27, MEFV mutations and X-ray of swollen joint were performed for all patients. Temperature was also measured.

Results: Mean age of patients with acute monoarthritis was 46.13 years. Female predominance was noted (61%). 71% of patients had elevated ESR, 69% CRP. In 24% of cases homozygous or heterozygous mutations of MEFV gene were revealed. 21% of patients had positive RF and 18% - anti-CCP. 11% patients carried HLA-B27 antigen. 28% of examined patients had subfebrile fever. Hepatosplenomegaly was detected in 16%, uveitis in 5%, psoriatic plaque in 4%, interstitial pneumonia in 2% of cases.

At the baseline 82 patients were diagnosed with rheumatologically disease. Baseline data is shown in the Table 1 below.

Table 1. Baseline data

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>FMF</td>
<td>23</td>
</tr>
<tr>
<td>Osteoarthritis (reactive synovitis)</td>
<td>16</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>15</td>
</tr>
<tr>
<td>Reactive arthritis</td>
<td>10</td>
</tr>
<tr>
<td>Ankylosing spondylitis</td>
<td>6</td>
</tr>
<tr>
<td>Psoriatic arthritis</td>
<td>4</td>
</tr>
<tr>
<td>SLE</td>
<td>3</td>
</tr>
<tr>
<td>Schonlein-Henoch purpura</td>
<td>2</td>
</tr>
<tr>
<td>Sarcoïdosis</td>
<td>2</td>
</tr>
<tr>
<td>Behcet diseases</td>
<td>1</td>
</tr>
</tbody>
</table>

Conclusion: In this study monoarthritis in majority of cases underlies FMF. Though FMF is not considered as a frequent cause of acute monoarthritis, more attention should be paid on this pathology in focus of monoarthritis, especially in specific for FMF region. Further follow up of acute monoarthritis progression is needed.

REFERENCES:

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.3705

AB0784  SPINAL HYDATID CYST DISEASE: WHAT FEATURES IN SURGICAL DEPARTMENTS?

A. Dghais1, R. Dhahri1, M. Slouma1, L. Metou1, I. Ghasala1, R. Ayar2, Y. Malat3, K. Amri3, M. Alou4, Y. Arous3. 1The Military Hospital of Tunis, Rheumatology, Tunis, Tunisia; 2The Military Hospital of Tunis, Traumatology-Orthopedic Department, Tunis, Tunisia; 3The Military Hospital of Tunis, Radiology, Tunis, Tunisia

Background: Cystic echinococcosis (CE) is a zoonosis caused by the larve of Echinococcus granulosus. Cysts can develop in any part of the body, although the liver and lungs are most frequently involved. Bone echinococcosis is one of the rarest forms of the disease, accounting for 0.5 to 4.0% of all echinococcosis. Spinal cysts are disabling causing destruction similar to malignant bone lesions, with high risk of neurological deficit.

Objectives: To increase awareness of this disease, the clinical data of eight patients with spinal CE were analyzed retrospectively.

Methods: Clinical data of eight patients with spinal CE were analyzed retrospectively, collected over ten years on the department of orthopedics in the Military hospital of Tunis.

Results: The mean age of the patients was 49 years. The median disease duration was five years. All patients presented with back pain and parasthesia without neurological deficit. Radicular pain was reported by two patients. The diagnosis of spinal CE was made after the diagnosis of visceral CE in two patients. Former X rays showed nonspecific abnormalities and patients were treated initially by symptomatic treatments based on paracetamol and nonsteroidal antiinflammatory drugs without any improvement. All of the patients needed Magnetic resonance imaging (MRI) to explore chronic back pain with paresthesia, revealing spinal CE. The typical MRI appearance is a multicellular cyst. Six patients had cervical and thoracic spinal cysts, one patient had a lumbar spinal cyst and one patient had cervical, thoracic and lumbar cysts. Further examinations with Computed tomography scans (CTscans) were needed before surgery for better examination bone destruction. All patients underwent surgery.
Cysts were removed with spinal fixation. All the patients showed relapses and needed at least three surgical interventions.

**Conclusion:** Bone echinococcosis is rare and often misdiagnosed. Radiographic and CT images lack disease-specific characteristics whereas MRI images offers a greater chance of direct diagnosis. Treatment of spinal hydatid disease is entirely surgical with high risk of relapses.

**Disclosure of Interests:** None declared

**DOI:** 10.1136/annrheumdis-2021-eular.3986

---

**AB0785**  
**TREATING IDIOPATHIC RECURRENT PERICARDITIS WITH INTERLEUKIN-1 INHIBITORS - A SINGLE CENTER EXPERIENCE**  
**P. Andrei** 1,2,3, S. Brådland2, G. Haugeberg1,4, 1.Østfold Hospital Trust, Department of Cardiology, Sarpsborg, Norway; 2.University of Oslo, Department of Clinical Medicine, Oslo, Norway; 3.Hospital of Southern Norway, Department of Rheumatology, Kristiansand, Norway; 4.Norwegian University of Science and Technology. Department of Neuromedicine and Movement Science, Faculty of Medicine and Health Sciences, Råndheim, Norway

**Background:** Pericarditis is a common disease with significant morbidity (1). Idiopathic pericarditis, where an underlying cause cannot be identified, makes up for 80% of cases in the Western World (1). Up to 30% of these patients experience recurrence despite optimal treatment (2). Idiopathic recurrent pericarditis (IRP) is thought to represent an auto-inflammatory process rather than a reinfection (3). 2015 European Society of Cardiology (ESC) guidelines have outlined treatment of acute episodes and first recurrence with nonsteroidal anti-inflammatory drugs (NSAID), acetylsalicylic acid (ASS) and Colchicine as first line and Glucocorticoids (GC) as second line treatment (3). However GC treatment increases the risk of relapse, dependence and toxicity (2). Interleukin-1 (IL-1) inhibitors have been proposed as possible treatments in IRP (3, 4).

**Objectives:** The aim of this case study is to outline our first experiences treating IRP with the IL-1 inhibitor anakinra in our Rheumatologic clinic.

**Methods:** All patients referred to our department in 2018/2019 with pericarditis were physically seen in our outpatient clinic. All patients were screened for malignancy, infection or rheumatic disease as possible cause by clinical measures. Following ESC guideline, patients who suffered either the third recurrence under optimal treatment or significant side effects or dependency from GC were considered for anakinra treatment. Daily injection of anakinra (100mg) were given continuously over at least three months with gradual tapering over at least three months afterwards. Physical emergency department contacts, days hospitalized, colchicine- and GC use, the year prior to Anakinra treatment was recorded retrospectively. During follow up the same data was prospectively recorded.

**Results:** Over the course of two years 20 patients were referred to our clinic. All fulfilled ESC diagnostic criteria for pericarditis at index episode. In none of the patients could a rheumatologic, infectious or malignant cause be identified. 16 patients could be treated according to 2015 ESC guidelines with first or second line agents. Four patients were aligned to anakinra treatment. Prior to referral, duration of symptoms was 5 - 120 months (mean 61 months). Further relevant patient-characteristics are outlined in Table 1. After initiation of anakinra patients were afterwards regularly followed up in scheduled visits every 3 months.

**Table 1. Characteristics of the four patients aligned to anakinra prior to anakinra-initiation.**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Number of recurrences</th>
<th>Number emergency hospital contacts related to IRP the year prior to anakinra</th>
<th>Days hospitalized related to IRP the year prior to anakinra</th>
<th>GC dose prior to anakinra</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>7.5 mg steriodglaucoma</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>7</td>
<td>2</td>
<td>4</td>
<td>10 mg</td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>4</td>
<td>7</td>
<td>22</td>
<td>20 mg</td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>7</td>
<td>3</td>
<td>12</td>
<td>20 mg</td>
<td></td>
</tr>
</tbody>
</table>

Follow-up after start of anakinra was 6-15 months (mean 11.5 months). No patient was admitted to hospital or emergency department in that period. All four patients could taper and stop GC without recurrence. One patient experienced a mild relapse after discontinuing anakinra and was restarted on a low dose with complete remission. No patient had elevated CRP values at the end of follow-up and no patient experienced tamponade or clinical signs of constriction. No significant side effects were noted, no patient had to stop anakinra-treatment during follow up.

**Conclusion:** Implementation of anakinra treatment in cases of complicated IRP was both secure and successful in our rheumatologic outpatient department. In our small sample we could confirm findings from bigger trials regarding effect and side effect rates of anakinra treating IRP.

**REFERENCES:**


**Disclosure of Interests:** None declared

**DOI:** 10.1136/annrheumdis-2021-eular.4037