age between 36 and 65 (79.3%, vs 82.1%). Most of the respondents declared treating patients with CGD (93.1%, vs 79.1%). Regarding treatment modalities, physical therapy was the most prescribed in both specialties (81.5% and 48.3%, respectively). Only RTO (18.5%) prescribed manual therapy. Concerning medical treatment, anti-inflammatory were the most prescribed drugs in both groups (92.6, and 34.5%, respectively). Sixty-seven percent of RTO prescribed anti-vertigo medication. Interestingly, it was the least prescribed drug by ORL (6.9%). Only RTO (59.3%) prescribed Muscle relaxants.

Conclusion: Despite the disparities in the management of CGD, physical therapy remains the first prescribed treatment by Tunisian doctors. Further studies are needed to establish a consensus to treat CGD.

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POS1275 PERITENON THICKENING IS ASSOCIATED WITH THE INTENSITY OF MANUAL SPORTS ACTIVITY

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Background: Peritenon enlargement has been considered as a specific ultrasound finding associated with psoriatic arthritis based on studies in patients. Recent observations in athletes have demonstrated the existence of this finding although its relationship with the type of physical activity performed has not been determined.

Objectives: To determine to what extent manual physical activity is associated with the prevalence of peritenon thickening in the fingers of healthy athletic subjects.

Methods: Thirty-five healthy young male volunteers were recruited from a local sports centre in the community of Madrid. All of them performed sports activities with their hands for more than 12 hours a week. A digital dynamometer was used to determine the flexion strength of the fingers of the dominant hand. A single observer performed an ultrasound scan of this hand to determine the presence or absence of a hypoechoic image surrounding the extensor digitorum tendon of the 2nd, 3rd, 4th and 5th fingers, according to previous definitions. Mean flexion strengths were compared with the number of positive ultrasound findings.

Results: Fifteen volunteers (mean age 24.3 years, BMI 24.4) did not present peritenon enlargement (42.8%). The mean $\pm$ standard deviation of the fingers flexor strength according to the number of peritenon enlargement detected were 43.5 $\pm$ 6.2, 49.2 $\pm$ 3.8, 53.2 $\pm$ 1.64 and 63.0 $\pm$ 4.83 Kg for volunteers with none, 1, 2, 3 and 4 peritenon enlargements, respectively. (ANOVA $P < 0.001$; Pearson's coefficient 0.827, $P < 0.001$). Correlation between BMI, body fat percentage or training hours per week and the number of peritenon enlargement detected was not demonstrated.

Conclusion: Peritenon enlargement, also known as peritenon tendon inflammation, is detectable by ultrasound scan in healthy subjects and it seems to be associated to the physical activity intensity, indirectly measured by the flexor strength of the fingers.

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POS1276 LONG TERM OUTCOME OF MULTIPLE ULTRASOUND GUIDED SUPRASCAPULAR NERVE BLOCK IN TREATMENT OF FROZEN SHOULDER IN DIABETIC PATIENTS

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Background: Frozen shoulder is prevalent among diabetic patients, and usually has aggressive course, with more tendency to be bilateral and resistant to treatment. Suprascapular nerve block (SSNB) is used with increasing frequency by anesthetists and rheumatologists in the management of frozen shoulder. We previously introduced a protocol of nine injections for SSNB with better short term outcome than single SSNB injection (1). Long term outcome of SSNB in management of frozen shoulder is still not detected.

Objectives: To evaluate the long term effect of multiple (nine) ultrasound guided supra-scapular nerve block in treatment of diabetic frozen shoulder.

Methods: A retrospective cohort study followed up 40 diabetic patients who received a course of ultrasound guided multiple supra-scapular nerve block (9 injections) on 2014. In this study we retrospectively assessed the patients

from previously recorded data at a mean duration of 6 years after completing the 9 injection course SSNB clinically by measuring the shoulder active range of motion (using a goniometer in three planes: abduction, internal, and external rotation). Visual analogue scale and Functional assessment by shoulder pain and disability index (SPADI).

Results: Thirty four patients (85% of original cohort) completed the long term follow up.

The patients were 19 (55.9%) females, 60.6 y mean age, and the mean of disease duration was 85.6 months. The majority of patients (33 patients 97.05%) continues improvement and gained within normal complete range of motions in all directions and excellent grades of shoulder function (Table 1).

Table 1.

Clinical Parameters	At base line	At 4 months	Last follow up at (72months $\pm$ 4)	**P value
SPADI pain score (100)	(68.8 $\pm$ 0.5)a	(10.3 $\pm$ 7.4)b	(0.9 $\pm$ 1.9)c	0.00*
SPADI disability score (100)	(69.2 $\pm$ 7.7)a	(6.25 $\pm$ 2.25)b	(0.4 $\pm$ 0.8)c	0.00*
SPADI total (100)	(69.1 $\pm$ 8.5)a	(8.15 $\pm$ 5.4)b	(1.1 $\pm$ 0.9)c	0.00*
Patient global assessment (100)	(90.2 $\pm$ 8.2)a	(8.2 $\pm$ 4.2)b	(0.4 $\pm$ 2.1)c	0.00*
Night pain (100)	(55.4 $\pm$ 10.2)a	(10.3 $\pm$ 4.9)b	(2.3 $\pm$ 1.1)c	0.00*
Abduction (180°)	(77.5 $\pm$ 4.7)a	(170.3 $\pm$ 10.3)b	(174.2 $\pm$ 6.2)b	0.00*
External rotation (100°)	(46 $\pm$ 12.6)a	(80.1 $\pm$ 10.2)b	(86.4 $\pm$ 10.3)b	0.00*
Internal rotation (70°)	(34.5 $\pm$ 2.4)a	(55.4 $\pm$ 10.1)b	(60.2 $\pm$ 9.5)b	0.00*

* $P < 0.05$ there was a statistical significant difference. A, B, C --- the alphabet of different symbols --- means a significant statistical difference between groups. SPADI: shoulder pain and disability index

Conclusion: The multiple injection courses for supra-scapular nerve block has an excellent long term efficacy as treatment of diabetic frozen shoulder. This method should be the treatment of choice in patients of diabetic frozen shoulder who do not respond to physiotherapy.

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POS1277 NON-CONTIGUOUS MULTIFOCAL SPONDYLODISCITIS: A CASE SERIES AND REVIEW OF LITERATURE

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Background: Spondylodiscitis is an infective process of the disc and the two adjacent vertebrae. It is quite a rare disease accounting for 2–7% of all cases of septic osteomyelitis. These spinal infections touch commonly a single level, the lumbar spine being the most affected. Non-contiguous spine level involvement is seldom reported in the literature. This last group is for the most part imputable to granulomatous organisms [1,2].

Objectives: Study the clinical, microbiological, radiological, therapeutic and evolutionary characteristics of non-contiguous multi-levels spondylodiscitis.

Methods: We conducted a retrospective descriptive study over twenty-one years in the Department of Rheumatology. The diagnosis of spondylodiscitis was based on combination of clinical, biological and radiological arguments.

Results: Eight patients had non-contiguous multi-levels infectious spondylodiscitis. There were 6 men and 2 women. The mean age was 53.3 $\pm$ 26.2 years. The mean delay from onset of symptoms to diagnosis was 134.6 $\pm$ 77.6 days. Back pain was the most common symptom. All patients had spinal syndrome. The Signs of spinal cord compression were observed in 3 patients. C-reactive protein levels were elevated in 6 patients (mean: 56 $\pm$ 30.8 mg/L). Plain radiography, performed in all cases, showed pathological pictures in 7 patients. Magnetic resonance imaging was performed in 6 patients. Vertebral levels affected were thoracic / lumbar in 6 cases, cervical/thoracic in 1 case and cervical/lumbar in 1 case. The paravertebral abscess was associated to the disc involvement in 3 cases. Epiduritis was associated in 3 cases. Pathogens were isolated in all cases. Tuberculosis was the most common cause. The leading causative agents in non-tuberculosis spondylodiscitis were staphylococcus aureus, brucella and streptococcus B. Two microorganisms combined were found in two cases (mycobacterium tuberculosis associated to Escherichia coli in one case and mycobacterium tuberculosis associated to Brucella in another). Medical treatment was adapted to the microbial culture and the sensitivity profile of the etiological agent.