Conclusion: Elderly patients with infectious spondylodiscitis have fewer clinical symptoms leading to a delayed presentation. Increasing morbidity and mortality make rigorous monitoring necessary.

Disclosure of Interests: None declared

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AB1078

SPECTRUM OF INFECTIONS DURING RHEUMATOID ARTHRITIS
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Background: Immunosuppression during rheumatoid arthritis (RA) induced by the disease but especially immunomodulatory treatments, is responsible for an increased frequency of infections in these patients.

Objectives: The purpose of this study is to assess the incidence of infections during RA and to determine their nature and management.

Methods: A retrospective study over a period of 10 years, including 150 patients with RA. We identified 33 patients who had at least one infectious episode during their follow-up.

Results: There were 19 women and 14 men. The mean age was 51 years old [39-63]. RA was immunopositive and erosive in all cases. The average disease duration was 8 years. A comorbidity was associated with RA in 14 patients (42%): diabetes in 7 cases, hypertension in 3 cases, ethylism in 2 cases and history of pulmonary tuberculosis in 2 cases. As an extra-articular manifestation, 15% of patients had Sjogren's syndrome and 18% had pulmonary interstitial fibrosis (3 cases) or pulmonary nodules (3 cases). The most prescribed DMARDs was Methotrexate, prescribed in monotherapy at the average dose of 17.5mg/week [10-25mg] in 18 cases. The other patients received Methotrexate associated to Hydroxychloroquine in 4 cases, Sulfasalazine in 3 cases and biotherapy in 8 cases. Corticosteroid therapy at an average dose of 7.5 to 15mg/day was received in 16 cases (48.5%). All infections noted in our population were community acquired. Urinary tract infection was the most common infection noted in 15 cases: pyelonephritis in 3 cases and cystitis in 12 cases. Other infection sites were ENT in 4 cases, respiratory in 10 cases (2 cases of tuberculous infection and 8 cases of bronchopulmonary) in 12 cases. Thirteen patients consumed raw milk, eleven had contact with farm animals or contact with manure. The main symptom was unifocal or diffuse spinal pain associated or not with radiculalgia. Inflammatory pain was reported in 12 cases. Thirteen patients were diagnosed with tuberculosis and chronic brucellosis was noted in one case each. In 3 cases, rapid ankylosis was found on radiological control. Unfortunately, one patient died from septic shock.

Conclusion: Common germs are most responsible for infectious sacroiliitis and seem to have the best prognosis. Tuberculosis is responsible for various complications and its treatment has a high iatrogenic risk. Chronically is the most feared development, mainly during Brucella sacroiliitis and would be related to a loss of antibiotic efficacy.

Disclosure of Interests: None declared

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AB1080

BRUCELLAR SPONDYLODISCITIS: EPIDEMIOLOGICAL, CLINICAL AND BIOLOGICAL ASPECTS
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Background: Brucellosis is a systemic infection characterized by significant clinical polymorphism and non-specific manifestations. The spine is a common location for brucellosis.

Objectives: The aim of this study was to describe the epidemiological, clinical and biological characteristics of brucellar spondylodiscitis.

Methods: A retrospective study over a period of 15 years, including 18 patients diagnosed with brucellar spondylodiscitis on clinical, biological and/or imaging data.

Results: Eighteen cases were collected (13 men and 5 woman). The mean age was 52 years [19-76]. The main symptom was unifocal or diffuse spinal pain associated or not with radiculalgia. Inflammatory pain was reported in 12 cases. Thirteen patients consumed raw milk, eleven had contact with farm animals or professional exposure. The average duration of symptoms was 5.7 months [0.5-12], the disease had a progressive onset in 13 patients. The general signs were frequent: deterioration of general condition (13 cases), fever (12 cases) and night sweats (6 cases). All patients had a biological inflammatory syndrome. Wright’s serology, performed in 17 patients, was positive in 15 cases. The Rose Bengal test was positive in 13 of the 15 patients tested. Diagnosis by indirect immunofluorescence, performed in 11 patients, was positive in nine cases. However, the blood cultures, carried out in 13 patients and the disco-vertebral biopsy, carried out in 9 patients, did not find the causal agent.

Conclusion: The diagnosis of brucellar spondylodiscitis must be based on epidemiological, clinical arguments and biological examinations. Immunological examinations, however, seem to be more contributory and should be performed in case of diagnostic doubt and negative bacteriological investigation.

Disclosure of Interests: None declared