In the adult cohort, those contracting COVID-19 were more commonly from Russia (no COVID: 2%, COVID: 14%) and less commonly from the UK (no COVID: 82%, COVID: 71%, $p < 0.001$). There was greater female representation in those that contracted COVID-19 (no COVID: 88%, COVID: 93%, $p = 0.022$). Although there were no differences in overall presence of comorbidity ($p = 0.923$), kidney disease was overrepresented in those that had contracted COVID-19 (no COVID: 2%, COVID: 8%, $p < 0.001$). Finally, there were lower levels of social distancing in those who contracted COVID (no COVID: 54%, COVID: 44%, $p = 0.047$). There were no significant differences in age ($p = 0.203$), BMI ($p = 0.617$), smoking status ($p = 0.120$), rheumatic disease ($p = 0.181$) and its control ($p = 0.218$) or immunosuppressive use ($p = 0.208$) between those who did and did not contract COVID-19 in the adult cohort.

Conclusion: A low proportion of CYP and adults with rheumatic diseases contracted COVID-19 in the 9 months since March 2020. However, given the self-reported nature of the survey and limited testing available across many countries, this study may underestimate the true burden of COVID-19 in the rheumatic disease community. Factors associated with COVID-19 differ between CYP and adults, with age and type of rheumatic disease associated in CYP and gender, kidney comorbidity and social distancing associated in adults.

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AB0682 RHEUMATOLOGY TEACHING IN TIMES OF COVID-19

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Background: The COVID-19 pandemic has affected the delivery of face-to-face teaching especially bedside teaching for medical students in the hospitals. Rheumatology outpatient clinics have mostly become virtual or telephone consultation clinics which prevent medical students from seeing patients in person. Students are deprived of the opportunities to take rheumatology history, examining patients and seeing signs of rheumatologic diseases. New adaptations have to be made to ensure equitability and that students still receive the relevant teaching in line with their learning curriculum and to help them prepare for their examinations.

Objectives: Our aims are:

- 1) To adapt bedside teaching in the wards to simulated teaching in the classroom using trained simulated 'patients'; and
- 2) To create simulation teaching of patient journeys in Objective Structured Clinical Examination (OSCE) format known as Clinically Observed Medical Education Tutorials (COMET) (Nair et al., 2001).

Methods: 1) For simulated teaching in the classroom, we have trained our teaching colleagues as simulated or standardized patients (SPs). We write up fictitious patient histories which simulate common presentations at rheumatology clinics. We train the SPs to give as accurate a history as possible and to simulate pains in different joints (e.g. pain at the metacarpophalangeal joints and proximal interphalangeal joints in rheumatoid arthritis) on clinical examinations. For clinical presentations that are not easily simulated, we use photographs of the relevant signs. This method is used not only as formative assessments but also as end-of-placement summative assessments.

2) COMET comprises 3 OSCE-style stations with a tutor each where the students perform different tasks based on a patient's clinical problem (e.g. acute hot swollen joint). The first station is initial A-to-E assessment of the patient (using a simulator), followed by investigations and interpretations of lab results and imaging (station 2) and lastly, management (including prescribing medications) and communication skills (e.g. explain arthrocentesis to the patient).

Results: The overall feedback from students is very positive. We use Likert scale to assess confidence level before and after the teaching session, and pre-session and post-session multiple choice questions to assess learning and knowledge gained.

Conclusion: While simulated teaching cannot replace encounters with real patients, students do enjoy these sessions as they get to 'experience' a large variety of rheumatologic cases and practice their clinical skills which at times are limited with real patients due to reluctance and pain of the patients.

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AB0683 OSTEOPATHRITIS PAIN AND COVID-19 PANDEMIC: THE LOCKDOWN IMPACT

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Background: Both peripheral and central nervous system processes are involved in osteoarthritis (OA) pain. Several aspects such as environmental, psychological and constitutional factors contribute to OA pain and they were enhanced during and after lockdown, for COVID-19 pandemic.

Objectives: The purpose of this study is to assess the impact of the modified lifestyle forced by lockdown on joint pain using Visual Analogic Scale (VAS) scale. the variation of VAS pain, the reduction of physical activity, the variation of body weight, the stress values defined by Perceived Stress Scale (PSS) and the use of anxiolytics and antidepressant drugs were measured in OA patients during the lockdown period.

Methods: 74 adult patients affected by primary or secondary OA were included. The median age was 69.8 years old and 55/74 (74%) of the patients were female. Sex, age, comorbidities, pharmacological therapy, variation rate of VAS pain referred to OA symptoms (0-100) during lockdown, weight variation, degree of physical activity (defined as: absent 0h, low 1-5h, moderate 6-10h, high > 10h) were recorded. Perceived stress using PSS was recorded and patients were divided into two classes: low (0-13) or moderate-high (14-40) stress scale. This observational retrospective real-life study was conducted in May 2020. A linear regression model was used to analyze the different patients groups separately. Overall variables were expressed on analogic scales. To assess the impact on VAS pain, regression models were estimated with VAS pain as dependent variable, and weight increase, physical activity and perceived stress as independent variable.

Results: Patients enrolled with a pre lockdown VAS pain < 40 were 30, whereas 44 patients referred a pre lockdown VAS pain > 40. Patients taking anxiolytics, antidepressant, anxiolytics or antidepressant drugs were 14/74 (19%), 7/74 (9%), 19/74 (26%) respectively. PSS score Low (score 0-13), Med (score 14-26), High (score 27-40) was recorded in 34/74 (46%), 36/74 (49%), 4/74 (5%) patients respectively. Patients were divided in two different groups on the basis of baseline pre lockdown VAS pain: low VAS pain (< 40) (n=30) and moderate-high (≥ 40) (n=44). In the low-VAS group there was an average increase of pain by 1.36 points, an average increase of weight by 0.63kg, and an average decrease of weekly physical activity by 6.4 hours that was statistically relevant ($p < 0.0001$). In moderate-high VAS group an average increase of pain and weight, by 2.62 points and 0.35 kg respectively, and a significant decrease of physical activity by 3.15 h weekly ($p < 0.0001$) has been recorded

	MODERATE PAIN (VAS<40) (n=30)		HIGH PAIN (VAS≥40) (n=44)	
	Before LD	During LD	Before LD	During LD
Gender, Female: n (%)	17 (56.7%)		38 (86.4%)	
Age (years) : median (Q1, Q3)	63 (57,73)		73 (66, 79)	
Weight (Kg) : median (Q1, Q3)	66.5 (57.0,76.5)	67.5 (58.0, 77.7)	64.0 (57.7, 74.2)	67.0 (57.7, 75.0)
Physical activity (h/week) : n (%)	0 (0.0%) 4 (13.3%) 1-5 (46.7%) 6-10 12 >10 (40.0%)	11 (36.7%) 10 (33.3%) 6 (20.0%) 3 (10.0%)	10 (22.7%) 10 (22.7%) 18 (41.0%) 6 (13.6%)	26 (59.0%) 12 (27.3%) 5 (11.4%) 1 (2.3%)
Perceived Stress:n (%)		13 (43.3%) 15 (50.0%) 2 (6.7%)		21 (47.7%) 21 (47.7%) 2 (4.5%)
VAS PAIN (score) : mean (sd)	18.7 (10.4)	28.7 (22.1)	54.1 (10.0)	56.2 (16.3)