disease (n = 1), polyosteoarthritis (n = 6), benign osteopathy (n = 1). 17 patients were in low disease activity when they presented the COVID-19. 8 patients presented moderate to high activity, of which 2 (25%) developed a form requiring hospitalization. 7 patients were under NSAIDs, 13 under corticosteroids, 19 under csDMARD, 7 under bDMARD. The COVID-19 disease was symptomatic in 83% of cases, with fatigue (68%), cough (52%), back pain (48%), anosmia (48%), ageusia (44%), arthritis (44%), fever (36%). The diagnosis was made with polymerase chain reaction (83%), serology (10%), CT scan (23%). The CT lung lesions reached 25-50% in 2 lupus patients with a moderate disease activity, under corticosteroids and hydroxychloroquine. The involvement was > 75% in 2 patients, who admitted to intensive care: one was followed for polyarthrosis and was hypertensive and poorly balanced diabetic, and the other was followed for Horton's disease. The treatment was administered on an outpatient basis in 77.4% of cases, in an intensive care unit in 16% of cases. 30 patients fully recovered from infection, one patient died secondary to pulmonary embolism. The subgroup of patients on immunosuppressants consisted of 23 patients (76%), of whom 5 (22%) developed a moderate to severe form of COVID-19 requiring hospitalization. Among these hospitalized patients, 2 (40%) had moderate to high disease activity of their rheumatism.

Conclusion: Most of the patients in our series presented a mild form of COVID-19, including those under immunosuppressants. Patients who were under hydroxychloroquine were not spared from COVID-19, but developed a mild form. The disease activity of the chronic rheumatism did not appear to influence the severity of the COVID-19.

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AB0686

IMPACT OF COVID19 IN SPONDYLOARTHRITIS (SPA) PATIENTS IN A TERTIARY HOSPITAL

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Background: This tertiary hospital is the referral centre of 360.000 inhabitants, population with a Covid seroprevalence of 8,4% at final 2020.

Since march, we have had a special concern for rheumatologic patients with systemic diseases and under immunosuppressive agents, including disease modifying antirheumatic drugs (DMARDs) and biological therapy (BT). This is why a special protocol for this population was set. It included performance of serology (CLIA test) for patients under BT and PCR and CLIA testing prior to new treatments. PCR testing was also generally performed: if symptomatology consistent with Covid; before hospitalisation; to tight contacts of infected people; and before procedures.

Objectives: To evaluate the impact of COVID-19 in our SpA patients in terms of severity of viral infection and its effect on SpA.

Methods: Data of 665 SpA patients and confirmed Covid infection seen in our center from March 15th to December 15th was crossed. 3 miscoded patients with rheumatoid arthritis and 2 with non definite CLIA positivity were excluded. Finally 49 patients' clinical records were reviewed. Data regarding epidemiologic features, SpA characteristics, comorbidities, therapy received, clinical activity before and after Covid, and severity of the infection was collected. IBM SPSS v23 was used for statistical analysis.

Results: Among 49 SpA patients, 59% were male, mean aged 56,63 years (range 23-79). 62,2% presented at least 1 comorbidity. 65% were psoriatic arthritis. They mostly had longstanding disease (median 10,5 years -range- 1-35). Previously 63% had received DMARDs, mainly methotrexate, and 32 % BT.

When Covid was diagnosed 37,2% were under DMARDs and 53% under BT (69,2% TNF inhibitors, 26,9% anti-IL 17, 3,9% ustekinumab). At this point, disease activity was controlled in 82% of patients (39% in remission, and 43% in low disease activity state). Only 18% showed moderate activity.

Within the 49 patients, 34 were diagnosed by PCR and 15 by CLIA tests. 9 required hospitalisation, of whom 4 developed more severe disease (3 received glucocorticoid pulses and 2 tocilizumab). A woman with PsA under secukinumab presented pneumonia and PE. None required mechanical ventilation. There were no exits.

Due to Covid infection 9 patients (50%) stopped DMARDs treatment, (5 of them hospitalised). 9 patients withdrew BT after Covid diagnosis; 60% of the BT-hospitalised, and 28,5% of the BT- non-hospitalised. 1 suffered a flow with severe disease activity after withdrawal of IL-17 inhibitor.

Conclusion: Prevalence of SARS cov 2 infection in SpA patients was not greater than in general population. Most were asymptomatic or suffered mild disease. Only 9 were hospitalised. Factors related to hospitalisation seem similar to those of general population, even if statistical significance was not found due to the small sample. BT does not seem to relate to hospitalisation in SpA and we had no deaths to date in them.

More studies should be made to throw out conclusions.

Baseline characteristics of SpA patients with confirmed Covid19	Hospitalised (N 9)	Non-hospitalised (N 40)	Total (N 49)
Mean age (range) – yr	62,56 (43-74)	55,3 (23-79)	56,63 (23-79)
Male sex - no. (%)	6 (66,6)	23 (57,5)	29 (59,1)
Smoking habit (active, ex-smokers) - no. (%)	2 (22,2)	23 (57,5)	25 (51)
Non comorbidities - no. (%)	2 (22,2)	17 (42,5)	19 (38,8)
Hypertension - no. (%)	3 (33)	14 (35)	17 (35)
Diabetes - no. (%)	1 (11)	6 (15)	7 (14,2)
Dyslipidemia - no. (%)	4 (44)	9 (22,5)	13 (26,5)
Obesity (BMI >30) - no. (%)	4 (44)	12 (30)	16 (32,7)
Chronic obstructive pulmonary disease - no. (%)	2 (22,2)	4 (10)	6 (12,2)
Asthma - no. (%)	0 (0)	4 (10)	4 (8,2)
Cardiopathy - no. (%)	1 (11,1)	8 (20)	9 (18,4)
Median disease time since diagnosis (range) – yr	14, 5 (7-20)	10 (1-35)	10,5 (1-35)
SpA type			
Psoriatic arthritis - no. (%)	8 (88,8)	24 (60)	32 (65,3)
Ankylosing spondylitis - no. (%)	1 (11,1)	15 (37,5)	16 (32,7)
Non-Rx ankylosing spondylitis - no. (%)	0 (0)	1 (2,5)	1 (2)
Current treatment when diagnosed (N 48)			
DMARDs - no. (%)	6 (66,6)	12 (30)	18 (37,5)
BT - no. (%)	5 (55,5)*	21 (52,5)**	26 (54,1)
* 5 anti-TNF (1 etanercept), 2 anti IL-17, 1 anti IL-12-23.			
** 12 anti-TNF (4 etanercept), 5 anti IL-17.			

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AB0687

EFFECT OF COVID-19 ON PATIENTS ATTENDING AMBULATORY DEEP VENOUS THROMBOSIS OUTPATIENT CLINIC: A RETROSPECTIVE, COHORT ANALYSIS[K11] [K11]101 CHARACTERS

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Background: COVID-19 has been acknowledged as an procoagulant disorder with increased risk of venous thromboembolism (VTE) [1]. High rates of VTE in patients admitted to intensive care unit have been reported [2]. However effect of COVID-19 on ambulatory patients attending out-patient clinics has not been described.

Objectives: This retrospective, observational cohort study analyses the impact of COVID-19 on incidence of Deep Venous Thrombosis (DVT) in patients referred to Ambulatory Deep Venous Thrombosis Out-patient Clinic (ADOC). A comparative analysis of patients attending ADOC during a similar period in 2019 is undertaken.

Methods: Patients who attended the ADOC with suspected DVT during the 'first wave' of the COVID-19 pandemic between 01 February and 30 June 2020 at Southport and Ormskirk NHS Trust were studied and compared to a similar period in 2019. Patients characteristics, comorbidities, risk factors, incidence of DVT and relationship with COVID-19 with the evaluation of haematological parameters including D-dimer and two-tier Wells score. Additionally we examined patients outcomes including morbidity, mortality and hospital admissions.

Results: Overall, there was a decrease in the number of patients attending the ADOC from 290 in 2019 to 233 in 2020. However, a total of 38 patients tested positive for DVT, a rate of 16.3%, which is compared to an incidence of 7.9% in 2019. Due to evolving protocols, the COVID-19 status of all patients attending the ADOC could not be ascertained. However, 5/233 of the 2020 cohort patients either had a positive test result (n=4) or were symptomatic of COVID-19 (n=1).

Conclusion: There has been a 129% increase in the incidence of DVT in patients presenting to ADOC at our trust during the 'first wave' of the COVID-19

pandemic. Furthermore, despite fewer patients presenting with DVT symptoms to the ADOC, there appears to be a higher incidence of confirmed DVTs in ambulatory patients during COVID-19.

Although there is a strong association inferred between COVID-19 and VTE [3], lack of access to SARS-CoV-2 nasal swab testing of patients attending ADOC for VTE assessment was a limiting factor to establish an association in this study. Because of this, we cannot extrapolate a definite association in patients with mild to moderate COVID-19 illness in the community and DVT.

What we postulate is perhaps the higher incidence in the 2020 cohort could be a marker for a mild case of asymptomatic COVID-19 in these patients. Currently there is no guidance as to whether point of care testing should be available in ADOC. We wonder whether a point of care COVID-19 testing of these patients would have positive impact on the rate at which COVID-19 is identified in the community. Furthermore patients have been avoiding hospitals during the pandemic, greater testing should help to reassure and encourage them to seek help earlier during their illness, minimising potential complications such as PE, hospital admission and death.

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AB0688

SEVERITY OF COVID-19 INFECTION IN RHEUMATIC IMMUNE-MEDIATED INFLAMMATORY DISEASES. STUDY IN A SINGLE UNIVERSITY HOSPITAL

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Background: Immune-mediated inflammatory diseases (IMID) may have a global increased risk of infections due to the disease itself, and/or immunosuppressive therapy. The severity and characteristics of COVID-19 in patients with rheumatic IMID (R-IMID) remain unknown.

Objectives: To analyze the severity of COVID-19 infection in R-IMID.

Methods: Cross-sectional study in a single University Hospital. We included all consecutive patients with a diagnosis of a R-IMID and a positive test for COVID-19 up to November 6th, 2020. Confirmed infection was defined if the patient had a positive nasopharyngeal swab for SARS-CoV-2.

Medical records of 11,199 patients with COVID-19 in our region, and 6891 with R-IMID from our hospital were reviewed.

COVID-19 case severity was divided into mild, moderate, severe and critical according to the United States National Institute of Health (NIH) COVID-19 guidelines (1). Mild/moderate COVID19 was compared with critical.

Results: We included 147 patients (96 women/51 men), mean age 60±18 years. Most cases were mild to moderate (n=123, 83.7%), 30 of them (20.4%) were asymptomatic. The remaining patients presented severe (n=5, 3.4%) or critical (n=19, 12.9%) disease (Table 1). Fatal outcome occurred in 12 patients (8.2%).

More frequent underlying R-IMID were Rheumatoid Arthritis (n=36; 24.5%), Psoriatic Arthritis (n=30; 20.4%), axial spondyloarthritis (n=24; 16.3%), connectivopathies (n=19; 12.9%), polymyalgia rheumatica (n=16; 10.9%) and vasculitis (n=9; 6.1%) (Figure 1).

Main comorbidities were hypertension (n=65, 44.2%), dyslipidemia (n=64, 43.5%), age higher than 65 years old (n=55, 37.4%), obesity (n=35, 23.8%), coronary vascular disease (CVD) (n=27, 18.4%) and diabetes mellitus (n=22, 15%).

Comorbidities and R-IMID associated with critical disease (p<0.05) were hypertension, age higher than 65 years, CVD and Polymyalgia Rheumatica. Critical compared with mild/moderate disease showed significantly higher levels of creatinine and D-dimer, and lower level of lymphocytes and platelets (Table 1) and received more frequently systemic glucocorticoids. Tocilizumab and Anakinra were used only in critical patients, 2 cases each.

Conclusion: Although most cases are mild, COVID-19 can be a severe life threatening disease in patients with R-IMID. Hypertension, older age, CVD and polymyalgia rheumatica were associated with critical disease.

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Table 1. Clinical severity of 147 with R-IMID diagnosed with COVID-19, (analytical findings and Immunosuppressants are at COVID diagnosis)

	Overall N= 147	Mild/Moderate N= 123	Severe N= 5	Critical N= 19	Mild/moderate vs critical; p
Analytical findings (mean±SD)					
Creatinine (mg/dl)	1.04±1.14	1.27±0.65	1.18±0.47	1.35±0.61	0.001*
Platelets (x10 ³ /μL)	206 ±93	226 ± 95	154 ±87	159 ±62	0.01*
Lymphocytes (x10 ³ /μL)	1.11±0.65	1.27±0.65	0.8±0.29	0.71±0.5	0.001*
D-Dimer (ng/mL)	1162±1356	915±986	782±483	1947±2024	0.026*
Immunosuppressants, n(%)					
Oral GC	38 (25.9)	32 (26)	0	5 (26.3)	0.8
HCQ	25 (17)	23 (18.7)	0	2 (10.5)	0.58
MTX/ Other cDMARDs	27 (18.4)/19 (13)	26 (21.1)/18 (14.6)	0/0	1 (5.3)/1 (5.3)	0.18/0.45
TNF inhibitors	13 (8.8)	12 (9.8)	1 (20)	0	0.33
RTX	5 (3.4)	2 (1.6)	1 (20)	2 (10.5)	0.15
Other bDMARDs	13 (8.8)	10 (8.1)	1 (20)	2 (10.5)	0.28
JAKINIB	3 (2)	3 (2.4)	0	0	0.87
COVID-19 therapy, n (%)					
No treatment	94 (64)	88 (71.5)	1 (20)	5 (26.3)	0.0003*
HCQ	37 (25.2)	25 (20.3)	4 (80)	8 (42.1)	0.07
Systemic GC	17 (11.6)	8 (6.5)	1 (20)	8 (42.1)	0.00001*
Antivirals	20 (13.6)	13 (10.6)	0	7 (36.8)	0.07
Anti IL1/IL6 agents	4 (2.7)	0	0	4 (21.1)	0.00001*

GC: Glucocorticoids, HCQ: Hydroxychloroquine, MTX: Methotrexate, RTX: Rituximab

* P < 0.05

Figure 1. Severity of COVID-19 according to underlying R-IMID. Data are number of cases

GCA: Giant cell arteritis, PsA: Psoriatic arthritis, RA: Rheumatoid arthritis, SLE: Systemic lupus erythematosus, SpA: Axial spondyloarthritis, SSC: Systemic sclerosis.

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AB0689

INCIDENCE AND SEVERITY OF COVID-19 IN PATIENTS WITH SPONDYLOARTHRITIS IN ARGENTINA: EXPERIENCE IN A COUNTRY WITH STRICT ISOLATION

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