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
COVID-19 therapy, n (%)					
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
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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