practice was inferior to 5 years in 59.3%, between 5 and 10 years in 18.5%, and superior to 10 years in 22.2% of cases. Sixty-three percent of rheumatologists reported that their activity decreased during covid-19 pandemic. NSAIDs prescription was avoided as much as possible in 40.7% of cases.

The participants indicated NSAIDs less frequently in 33.3% of cases, and as much as before the pandemic in one-quarter of cases.

Rheumatologists believed that NSAIDs worsen the respiratory symptoms (67%), delay recovery (55%), and increase mortality (48%), hospitalization in intensive care (44%), and infectious complications (33%).

The participants suggested that the most incriminated NSAIDs were: Ibuprofen (7.4%), indomethacin (7.4%), celecoxib (7.4%), and diclofenac (3.4%). The majority of rheumatologists (74%) believed that all NSAIDs had a similar risk.

For patients with osteoarthritis, rheumatologists replaced NSAIDs with paracetamol and corticoids in 78% and 11% of cases, respectively. If mandatory, reducing NSAIDs doses or duration was an option in 22% and 74% of cases.

For patients with SpA, half of rheumatologists did not change the treatment. However, the participants limited the use of NSAIDs or discontinued the treatment in patients with comorbidities. More than 60% of rheumatologists didn't know the effect of NSAIDs in the post-covid-19 syndrome.

Conclusion: Covid-19 pandemic has affected rheumatologists' practice. Rheumatic disease management during this pandemic may be challenging. More evidence is mandatory to standardize treatment prescription, especially with NSAIDs.

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AB0694

COVID-19 INFECTION IN PATIENTS WITH RHEUMATIC DISEASES: TWO CENTERS EXPERIENCE

A. Şahin¹, M. A. Gedikli², M. E. Derin³, B. Karakaş¹, B. Karataş¹, N. Çabuk Çelik¹, İ. Yalçın¹. ¹Sivas Cumhuriyet University, Internal Medicine – Rheumatology, Sivas, Turkey; ²Sivas Cumhuriyet University, Internal Medicine, Sivas, Turkey; ³Sivas Numune Hospital, Internal Medicine – Rheumatology, Sivas, Turkey

Background: Coronavirus disease 2019 (COVID-19) is a new viral infection characterized by dry cough, fever, shortness of breath, fatigue and lymphopenia. It may be complicated by interstitial pneumonia leading to severe acute respiratory distress syndrome(1). The COVID-19 outbreak has increased concerns in those with rheumatological diseases(2).

Objectives: To present the clinical course of COVID-19 infection in patients with rheumatological disease and comorbid conditions of patients and drug use.

Methods: 70 COVID-19 patients with autoimmune and autoinflammatory rheumatic diseases over the age of 18 who were followed up in the internal diseases-rheumatology department of Sivas Cumhuriyet University Hospital and Sivas Numune Hospital between April 2020 and January 2021 were included in this study. An application was made to the ethics committee of Sivas Cumhuriyet University Hospital and approval was obtained. Demographic data, comorbidities, smoking, treatments for their diseases, symptoms and hospitalization status of the patients were evaluated.

Results: The median age of the women patients was 48 years (min: 20-max: 73), 41 years in men (min: 21-max: 78). 15 patients (21.4%) were male, 55 patients (78.6%) were female. The most common rheumatic disease was rheumatoid arthritis (RA, 21, 30%) followed by ankylosing spondylitis (19, 27.1%), familial Mediterranean fever (13, 18.6%), Behçet's disease (12, 17.1%). 22 (31.4%) patients hydroxychloroquine sulfate, 14 (20%) leflunomide, 7 (10%) patients methotrexate, 6 (8.6%) patients sulfasalazine, 10 (14.3%) patients azathioprine/ mycophenolate mofetil, 22 (31.4%) patients were using colchicine. As a biological medicine; 20 (28.6%) patients were using infliximab, 5 (7.1%) patients were using adalimumab, 6 (8.6%) patients were using rituximab, and 4 (5.7%) patients were using tocilizumab. Other are summarized in Table 1. The most common comorbidities were hypertension (25.7%) and diabetes mellitus (DM 17.1%). While 56 patients (80%) had symptoms of COVID-19, 14 patients (20%) were asymptomatic. The most common symptoms was fever (32, 45.7%) followed by cough (29, 41.4%), dyspnea (28, 40%), myalgia (25, 35.7%), loss of taste and smell (18, 25.7%). 21 pneumonia cases were diagnosed. 22 (31.4%) patients were hospitalized. Mortality rate was 2/70, 2.9%. Two RA patients who just treated with rituximab and tocilizumab were died. 10 cases were using >10mg/day prednisolone, 2 died, 8 cases were hospitalized and had severe disease. They had hypertension and DM. Characteristics of the patients are summarized in Table 2.

Conclusion: The course of COVID-19 in rheumatic diseases is not clearly. Meta-analysis has shown that the frequency of COVID-19 is increased in autoimmune diseases. However, this increase was mostly associated with the use of >10mg/day prednisolone. It has been stated that the use of biological drugs and Dmard causes the SARS-CoV 2 process with a milder course and therefore their use is safe (3). Similar results have been obtained in global registry registers (4). In our data, there was no increase in the mortality rate compared to the normal

population. However, especially the use of rituximab may increase the rate of severe disease and mortality, so its use should be careful. There is a need for more comprehensive studies.

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PATTERN OF COVID-19 IN PATIENTS WITH RHEUMATIC DISEASES UNDERGOING BIOLOGICAL THERAPY: A COHORT EXPERIENCE

C. Ancuta^{1,2}, C. Pomirleanu^{1,2}, G. Strugariu², L. Petrariu², E. Ancuta³, C. Bran^{4,5}, R. Chiriac⁶, C. Mihailov^{7,8}. ¹University of Medicine and Pharmacy "GRIGORE T. POPA" IASI, Rheumatology, IASI, Romania; ²Clinical Rehabilitation Hospital, Rheumatology, IASI, Romania; ³"Elena Doamna" Clinical Hospital, Research, IASI, Romania; ⁴Emergency Hospital "Sf Ioan", Rheumatology, IASI, Romania; ⁵University Stefan Cel Mare Suceava, Semiology and Immunology, Suceava, Romania; ⁶Sanocare Medical and Research Center, Rheumatology, IASI, Romania; ⁷Clinical CF Hospital of Constanta, Rheumatology, Constanta, Romania; ⁸Faculty of Medicine, "Ovidius" University Constanta, Internal Medicine and Rheumatology, Constanta, Romania

Background: Despite emerging vaccines, the world is in the midst of a coronavirus disease 2019 (COVID-19) pandemic. Outcomes of SARS-CoV2 infection remain a major concern in patients with rheumatic and musculoskeletal diseases, especially for those with uncontrolled disease.

Objectives: We aimed to investigate trends and outcomes of COVID-19 occurring in patients with chronic inflammatory rheumatic conditions treated with biologics and targeted synthetic disease modifying antirheumatic drugs (bDMARDs, tsDMARDs).

Methods: We included all confirmed cases of COVID-19 regardless of severity in patients with rheumatoid arthritis (RA), ankylosing spondylitis (AS) and psoriatic arthritis (PsA) undergoing bDMARDs or tsDMARDs treatment registered in our local COVID-19 reporting database. We collected relevant information about comorbidities, rheumatologic-related clinical activity (RAPID5, SDAI, BASDAI, DAPSA), type of DMARD and glucocorticoid use, as well as COVID-19 related data as severity (ranging from asymptomatic to life-threatening forms), medication, hospitalization, intensive care unit admission, invasive mechanical ventilation and death.

We did a subgroup analysis among patients with a specific rheumatologic diagnosis, among different class of medication, patients who were or not hospitalized with COVID-19 looking how age, comorbidities, type of rheumatic condition and treatments impact COVID outcomes.

Results: 40 COVID-19 cases (positive PCR for SARS-CoV2) (4.67%) were identified during the 6-month study period among 855 patients registered in our database of patients under biologic treatment, including 20 RA, 18 SpA, 2 PsA patients. The majority were in either low disease activity or remission, only two patients had active uncontrolled disease at the onset of coronavirus infection.

16 cases (40%) were asymptomatic and were tested RT-PCR-positive during routine follow-ups for their disease, 13 cases (32.5%) had mild and 8 cases (20%) moderate illness; severe pneumonia and critical disease with acute respiratory distress syndrome were reported in only 3 cases, 2 recovered after; the only patients who died was 69 years old, had cardiac disease, hypertension and diabetes, had undertaken regular rituximab perfusion one month before coronavirus infection and developed pulmonary embolism followed by septic shock. Extreme fatigue was the dominant COVID-19 associated symptom apart from the classical ones including fever, cough, shortness of breath, sore throat, nasal congestion, headache, anosmia and ageusia myalgias and anorexia.

No specific pattern for patients requiring intensive care unit admission.

Conclusion: The COVID-16 infection rate in patients with inflammatory rheumatic disorders receiving biologics and tsDMARDs is pretty low; although immunosuppressed, these patients seem not to be at risk for severe COVID-19 illness and outcomes. These findings might reflect a potential protective role of certain biologics and/or JAK inhibitors for development and severity of COVID-19 in patients.