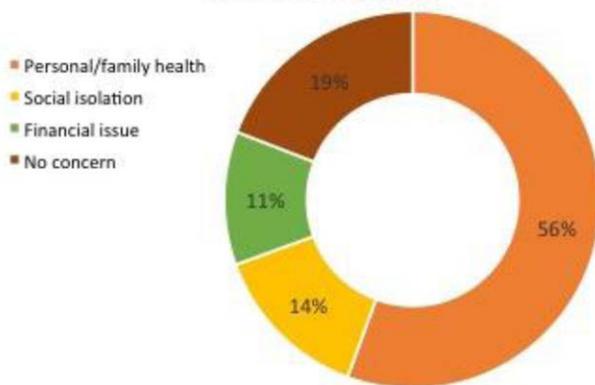


Background: A considerable psychosocial burden is one of the relevant consequences of the COVID-19 pandemic. In particular, quarantine measures have been related to negative psychological effects, including symptoms of post-traumatic stress disorder, stress, anxiety, and depression (1). This rise in mental health disorders might be even worse among people more vulnerable to psychological stress such as patients suffering from chronic rheumatic diseases (RDs). **Objectives:** The present Italian nationwide survey engages patients with rheumatic conditions through eleven associations of RD patients. It is conducted to establish the COVID-19 related self-reported poor mental health symptoms and to identify potential factors associated with these concerns among RDs who experienced the COVID-19 quarantine in Italy.

Methods: We collected data from May to September 2020 from RD patients living in Italy during the COVID-19 quarantine by an ad-hoc online survey. By using their mailing list and the related webpage and social network, eleven patients' associations sent a call to RD patients asking them to complete an anonymous online survey which included the Perceived Stress Scale (PSS), and the Impact Event Scale-Revised (IES-R). χ^2 tests were performed to detect statistically significant differences in both rating scale scores between groups defined by qualitative variables. Correlation analyses were realized with quantitative variables and rating scale scores. Variables significant in univariate analyses were then inserted in multivariate regression models.

Results: In total, 507 RD patients completed to the survey. 375 (73.9%) patients had inflammatory arthritis (243 rheumatoid arthritis, 76 psoriatic arthritis, 49 ankylosing spondylitis, and 7 Still's disease), and 96 (18.9%) with connective tissue diseases or systemic vasculitis. 31 (6.1%) patients had primary fibromyalgia and 5 osteoarthritis or crystal arthropathies. Self-reported major sources of anxiety are reported in the Figure 1 below.

Major sources of anxiety



The mean (SD) scores of the PSS-10 and the IES-R were 18.1 ± 8.1 and 29.7 ± 17.5 , respectively. With regard to the IES-R subscale scores, the total sample did not show a prominence of one of the three main domains (intrusion, avoidance and hyperarousal). Higher PSS scores were significantly associated with younger age ($p < 0.01$), female gender ($p < 0.01$), living outside Lombardy ($p = 0.03$), presence of overweight/obesity ($p = 0.01$), ongoing psychopharmacotherapy ($p < 0.01$), and anxiety for loss of incomes ($p < 0.01$). Female gender ($p < 0.01$) and living outside Lombardy ($p = 0.02$) were associated also with higher IES-R scores, together with the presence of intestinal diseases ($p = 0.03$), anxiety disorders ($p < 0.01$), and worries about health ($p < 0.01$).

Conclusion: This nationwide study revealed a high impact of self-reported distress, anxiety, and perceived stress among rheumatic patients after confinement during COVID-19 pandemic in Italy. Different factors were found to be predictive of poor mental health such as having female gender, younger age, living outside Lombardy, having overweight/obesity, or intestinal diseases, having a history of psychiatric symptoms (e.g. anxiety). Moreover, the lockdown experience worsened psychiatric symptoms and increased the assumption of psychopharmacotherapy in this vulnerable population. Prevention strategies focused on specific variables should be implemented to ameliorate psychological well-being of fragile patients during pandemics.

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POS1162

PREDICTORS OF HOSPITALISATION IN PATIENTS WITH RHEUMATIC DISEASE AND COVID-19 IN IRELAND: DATA FROM THE COVID-19 GLOBAL RHEUMATOLOGY ALLIANCE PHYSICIAN-REPORTED REGISTRY

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Background: There is limited data regarding the risk of hospitalisation in patients with rheumatic disease and COVID-19 in Ireland.

Objectives: We used the COVID-19 Global Rheumatology Alliance (GRA) registry data to study outcomes and their predictors.

	All significant variable model			Most parsimonious model	
	Unadjusted OR (95% CI)	Adjusted OR (95%CI)*	Adjusted p-value*	Adjusted OR (95%CI) [§]	Adjusted p-value [§]
Female	0.45 (0.20-1.02)	0.33 (0.05-2.23)		0.34 (0.09-1.36)	0.128
Age (years)	1.08 (1.05-1.11)	1.04 (0.97-1.10)	0.224	1.06 (1.01-1.10)	0.010
Inflammatory arthritis	0.11 (0.05-0.28)	0.14 (0.02-0.95)	0.044	0.09 (0.02-0.32)	<0.001
Connective Tissue Disease and Other	1.56 (0.62 - 3.92)				
No comorbidities	0.11 (0.04-0.30)	0.76 (0.09-6.58)	0.802		
Most common comorbidities					
COPD / asthma	4.77 (1.23-18.54)	3.09 (0.16-60.07)	0.456		
CVD	3.40 (1.31-8.85)	0.11 (0.01-1.88)	0.129		
Hypertension	3.71 (1.52-9.08)	0.56 (0.04-7.94)	0.668		
Obesity	0.58 (0.10-3.30)				
Number of comorbidities (Median, IQR)	3.01 (1.92-4.72)	2.99 (0.59-15.02)	0.184	1.93 (1.11-3.35)	0.020
Never Smoker	ref.				
Ever Smoker	3.17 (1.18-8.89)	1.19 (0.10-13.68)	0.889		
Medication prior to COVID-19 diagnosis					
Glucocorticoids	9.26 (1.95-43.89)	18.14 (1.13-290.81)	0.041	15.01 (1.77-127.16)	0.013
csDMARD monotherapy	0.42 (0.17-1.00)				
b/tsDMARD (monotherapy or in combination with csDMARD)	0.24 (0.10-0.58)	1.36 (0.19-9.72)	0.557		

Methods: We examined data on patients and their disease-related characteristics entered into the COVID-19 GRA provider registry from Ireland (24th March 2020 to 31st August 2020). Multivariable logistic regression was used to assess the association of demographic and clinical characteristics with hospitalisation.

Results: Of 105 patients, 47 (45.6%) were hospitalised and 10 (9.5%) died. Multivariable logistic regression analysis showed age (OR=1.06, 95%CI 1.01 to 1.10), number of comorbidities (OR=1.93, 95%CI 1.11 to 3.35), and glucocorticoid use (OR=15.01, 95%CI 1.77 to 127.16) were significantly associated with hospitalisation. A diagnosis of inflammatory arthritis was associated with a lower odds of hospitalisation (OR=0.09, 95%CI 0.02 to 0.32).

Conclusion: Increasing age, comorbidity burden, and glucocorticoid use were associated with hospitalisation, while a diagnosis of inflammatory arthritis was associated with lower odds of hospitalization.

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POS1163 CHARACTERISTICS AND OUTCOMES IN A REAL-WORLD COHORT OF RHEUMATOID ARTHRITIS PATIENTS WITH COVID-19

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Background: While some risk factors for severe COVID-19 outcomes have been identified for the general population and patients with rheumatic diseases (1-3), what drives these outcomes in specific rheumatic disease remains unclear. In addition, these findings need to be assessed across various observational data sources to ensure external validity.

Objectives: To describe the demographics, comorbidities, and severe COVID-19 outcomes among rheumatoid arthritis (RA) patients infected with SARS-CoV-2 in the United States.

Methods: A large nationwide electronic health record database (Optum, Inc.) in the United States, with data range between February 1, 2020 and September 17, 2020, was used to describe the demographics, comorbidities, and severe COVID-19 outcomes of RA patients with confirmed COVID-19 diagnosis (diagnosis for COVID-19 or positive PCR or antigen test). Patients with a single diagnosis of RA (ICD-10 code) before the diagnosis of COVID-19 were included. Patients missing age or sex, under 18 years of age on COVID-19 diagnosis date, or having less than 15 months of activity prior to COVID-19 diagnosis in the data source were excluded. We described demographics, comorbidities, and severe COVID-19 outcomes, including death, hospitalization, ICU admission, and acute respiratory insufficiency (ARI) identified between 14 days prior to and 30 days after COVID-19 diagnosis. Mean and standard deviation (SD) was reported for continuous variables. For categorical variables, count (N) and proportion was reported.

Results: We identified 2,948 patients diagnosed with RA and infected with SARS-CoV-2 (mean age± SD: 62 years ± 16, 77% female, 68% white). Of all identified patients, 38% were current or former smokers. For the 2,614 patients with BMI recorded, 78% were overweight or obese (mean BMI±SD: 31.2±8.3). The mean Charlson comorbidity index (CCI) was 3.6 (SD 3.2), with 87% of the study cohort having one or more comorbid condition, including hypertension (55%), type 2 diabetes (26%), COPD (20%), moderate to severe asthma (17%), coronary artery disease (17%), chronic kidney disease (13%), and heart failure (13%). Severe COVID-19 outcomes occurred in 618 (21%) patients. Among all RA patients with COVID-19, 137 patients (4.6%) experienced ARI, 484 patients (16.4%) were hospitalized (including 174 (5.9%) admitted to the ICU), and 155 patients (5.3%) died.

Conclusion: Underlying medical conditions that are known or possible risk factors of severe illness from SARS-CoV-2 infection in the general population

are common in this RA cohort from a large national EHR database. However, whether patients with RA are more vulnerable to severe COVID-19 outcome than the general population requires adjustment by age and other important confounders.

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POS1164 USE OF TELEMEDICINE FOR FOLLOW-UP OF SLE PATIENTS WITH NEPHRITIS IN THE COVID-19 OUTBREAK ("TELE-SLE"): THE 6-MONTH RESULTS OF A RANDOMIZED CONTROLLED TRIAL

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Background: Patients with lupus nephritis (LN) might be more susceptible to COVID-19 due to the underlying disease, co-morbidities and use of immunosuppressants. We hypothesized that telemedicine (TM) could be a well-accepted mode of health-care delivery minimizing the risk of exposure to the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), while maintaining disease control in these patients.

Objectives: To evaluate the short-term patient satisfaction, compliance, disease control and infection risk of TM compared with standard in-person follow-up (FU) for patients with LN during COVID-19.

Methods: This was a single-center randomized-controlled study. Consecutive patients followed at the LN clinic were randomized to either TM (TM group) or standard FU (SF group) in a 1:1 ratio. Patients in the TM group received scheduled follow-ups via videoconferencing. SF group patients continued conventional in-person outpatient care. The 6-month data were compared.

Results: From June to December 2020, 122 patients were randomized (TM: 60, SF: 62) and had attended at least 2 FU visits. There were no baseline differences, including SLEDAI-2k and proportion of patients in lupus low disease activity state (LLDAS), between the 2 groups except a higher physician global assessment score (PGA) in the TM group (mean 0.67±0.69 vs 0.45±0.60, p=0.003) (Table 1). The mean FU duration was 19.8±4.5 weeks. When comparing the most recent visit, the mean waiting time between entering the clinic waiting room (virtual or real) and seeing a rheumatologist (virtual or in-person) was significantly shorter in the TM group (22.5±28.6 vs 68.9±40.7 minutes, p< 0.001) (Figure 1A). The mean overall patient satisfaction score was higher in the TM group (mean 2.19±0.61 vs 1.89±0.78, p=0.042). The results of the post-consultation satisfaction questionnaire are shown in Figure 1B. The number of visits was similar in the two groups (TM: 3.1±1.3 vs SF: 3.0±1.2, p=0.981). However, there was a trend suggesting that alternative mode of FU was requested more frequently in the TM group than the SF group (TM: 12/60, 20.0% and SF: 5/62, 8.1%; p=0.057). More patients in the TM group had hospitalization (15/60, 25.0% vs 7/62, 11.3%; p=0.049) within the FU period, which was no longer statistically significant after adjusting for the baseline PGA. The proportions of patients remained in LLDAS were similar in the 2 groups (TM: 75.0% vs SF: 74.2%, p=0.919). None of the patients had COVID-19.

Conclusion: TM resulted in better patient satisfaction and could achieve similar disease control in patients with LN in the short-term when compared to standard care.