non-attendance reduced in 2020 to 6.5% from 10.9% in 2019 (OR 0.57 [95% CI 0.44-0.74]; $p < 0.001$), however the odds of discharging a patient from care were significantly lower in 2020 (3.9% vs 6%; OR 0.64 [95% CI 0.46-0.89]; $p = 0.008$), although there was no significance when patients who failed to attend were excluded. Amongst patients seen via telemedicine in 2020, a subsequent F2F appointment was required in 9.4%. The predictors of needing a F2F review were being a new patient (OR 6.28 [95% CI 4.10-9.64]; $p < 0.001$), not having a prior rheumatological diagnosis (OR 18.43 [95% CI: 2.35-144.63]; $p = 0.006$), or having a diagnosis of IA (OR 2.85 [95% CI: 1.40-5.80]; $p = 0.004$) or connective tissue disease (OR 3.22 [95% CI: 1.11-9.32]; $p = 0.031$).

Conclusion: Most patients in the 2020 cohort were seen via telemedicine. Telemedicine use during the COVID-19 pandemic was associated with reduced clinic non-attendance, but with diagnostic delay, reduced likelihood of changing existing immunosuppressive therapy, earlier requirement for review, and lower likelihood of discharge. While the effects of telemedicine cannot be differentiated from changes in practice related to other aspects of the pandemic, they suggest that telemedicine may have a negative impact on the timeliness of management of rheumatology patients.

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EXPECTATIONS AND POTENTIAL CONCERNS OF PATIENTS WITH AUTOIMMUNE AND RHEUMATIC DISEASES REGARDING VACCINATION AGAINST SARS-COV-2 (COVID-19): THE WORLDWIDE ONLINE VAXICOV STUDY

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Background: Vaccination is an important and effective tool to prevent infections in the general population as well as in patients with systemic autoimmune or inflammatory rheumatic diseases (AIIRDs) who may be at increased risk of serious infection. While the global race for vaccines against COVID-19 has already lead to first authorizations and vaccinations in some countries, multiple questions arise for access and provisions as well as for the acceptance of vaccine policies by immunocompromised patients.

Objectives: We conducted an international survey about expectations and potential concerns regarding SARS-CoV-2 vaccine in patients with AIIRDs and healthcare professionals.

Methods: The online study consisted of 57 questions which addressed determinants associated with SARS-2-CoV-2 vaccine willingness. Dissemination was ensured through social media and patient associations between December 12 and December 21, 2020.

Results: The study included 1266 patients with AIIRDs and 265 healthcare professionals from 56 countries. SARS-CoV-2 vaccine willingness was reported by 54.2% of AIIRD patients (uncertainty in 32.2% and unwillingness in 13.6%) and 74.0% of healthcare professionals. In patients, the willingness to get vaccinated increased significantly with age ($p < 0.0001$) and was strongly associated with the fear to be infected by SARS-CoV-2 ($p < 0.0001$) or to develop severe COVID19 ($p < 0.0001$) but not with presence of additional comorbidities ($p = 0.71$) or immunocompromised status ($p = 0.94$). The most trusted healthcare professional regarding the recommendation to get vaccinated against COVID-19 was their specialist (rheumatologist, internist, etc.) for 69.9%. Vaccine unwillingness was low (7.9%) among healthcare professionals and willingness was significantly increased in those who had been vaccinated against influenza in the last 3 years ($p = 0.01$).

Subject groups	Patients	Healthcare professionals
N	1266	265
Age (years), median [IQR25-75]	50 [40-61]	40 [32.5-53]
Female, n (%)	1141 (90.1%)	150 (56.6%)
Male, n (%)	115 (9.9%)	115 (43.4%)
Country, n (%)		
France	320 (25.3%)	159 (60%)
UK	345 (27.3%)	4 (1.5%)
Chile	123 (9.7%)	4 (1.5%)
USA	114 (9.0%)	7 (2.6%)
Venezuela	43 (3.4%)	26 (9.8%)
Spain	57 (4.5%)	3 (1.1%)
Mexico	53 (4.2%)	3 (1.1%)
Argentina	45 (3.6%)	8 (3.0%)
Other*	166 (13.1%)	51 (19.2%)
Rheumatic diagnosis, n (%)		
Systemic lupus erythematosus	492 (38.9%)	-
Spondyloarthritis	176 (13.9%)	-
Rheumatoid arthritis	160 (12.6%)	-
Giant cell arteritis / Polymyalgia rheumatica	144 (11.4%)	-
Primary anti-phospholipid syndrome	64 (5.1%)	-
Inflammatory myositis	62 (4.9%)	-
Relapsing polychondritis	45 (3.6%)	-
Other**	123 (9.7%)	-
-Health professionals, n (%)		
Doctor	-	265 (76.6%)
Nurse (or equivalent)	-	23 (8.7%)
Nursing assistant	-	11 (4.2%)
Other***	-	28 (10.6%)
Associated comorbidities, n (%)		
Diabetes	69 (5.5%)	6 (2.3%)
Hypertension	267 (21.1%)	24 (9.1%)
Myocardial infarction, stroke, transient stroke	60 (4.7%)	1 (0.4%)
Respiratory disease (asthma, chronic bronchitis, emphysema, etc.)	169 (13.3%)	13 (4.9%)
Renal failure	47 (3.7%)	1 (0.4%)
Obesity (BMI > 30)	228 (18.0%)	18 (6.8%)
At least one associated comorbidity, n (%)	588 (46.4%)	50 (18.9%)
Smoker, n (%)		
Current	128 (10.2%)	22 (8.3%)
Past	411 (32.7%)	51 (19.2%)
Never	719 (57.1%)	192 (72.5%)
Use of oral glucocorticoids, n (%)	551 (56.1%)	3 (1.1%)
Immunocompromised[§], n (%)	770 (60.8%)	0
On a 0 to 10 scale, median [IQR25-75]	8 (6-10)	5 (3-8)
	9 (7-10)	5 (1-8)
-Afraid to get infected by SARS-CoV-2		
-Afraid to get a severe COVID-19		
Willing to get vaccinated (Yes / uncertain / No), %	54.2 / 32.2 / 13.6	74.0 / 18.1 / 7.9
Vaccine hesitancy, n (%)	357 (28.2%)	59 (22.3%)

Conclusion: Data from this study are crucial to understand the main expectations and concerns regarding SARS-CoV-2 vaccination in patients with AIIRDs and healthcare workers and allow the identification of valuable strategies to increase vaccine coverage in those populations.

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