evolving pattern of the physical and psychological responses to the pandemic is ongoing.

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POS1242 FACTORS ASSOCIATED WITH MORTALITY IN PATIENTS WITH RHEUMATIC DISEASES AND COVID-19 IN MEXICO

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Background: As of the 25th of January 2021, more than 150 thousand deaths as consequence of COVID-19 have been reported in Mexico [1]. Advanced age, male gender and comorbidities have been described as risk factors for severe disease and mortality in general population [2]. COVID-19 mortality in Mexican patients with rheumatic and musculoskeletal diseases (RMDs) is unknown.

Objectives: To describe characteristics of Mexican patients with RMDs and COVID-19, and to analyse factors associated with mortality.

Methods: The Global Rheumatology Alliance COVID-19 (GRA) physician reported registry, is an international effort to collect information on COVID19 in adult patients with RMDs. GRA is an observational registry. The first patient from Mexico was registered on April 17, 2020. All Mexican patients registered in GRA until October 30, 2020 were included in this analysis. The association of mortality with demographic and clinical variables was estimated using logistic regression analysis.

Results: A total of 323 patients were registered, with a median age of 52 (IQR 41-61) years old, 166 (51.4%) patients lived in Mexico City. The most frequent RMDs were rheumatoid arthritis, 149 (46.1%) and systemic lupus erythematosus, 24 (19.8%). Over a third of patients with RMDs and COVID-19 (119 (36.8%)) were hospitalized, and 43 (13.3%) died. Table 1 shows clinical and demographic characteristics. In the univariable analysis, the absence of comorbidities was a protective factor, OR 0.3 (95% CI 0.1-0.6). Factors associated with mortality at COVID-19 diagnosis were age over 65 years old, having type 2 diabetes, chronic renal insufficiency, treatment at COVID-19 diagnosis with corticosteroids or with CD20 inhibitors. In the multivariable adjusted analysis, these factors remained independently associated with mortality. No associations with other treatments or comorbidities at COVID-19 diagnosis were found.

Conclusion: Mexican patients with RMDs and COVID-19 in the GRA physician reported registry had a mortality of 13.3%. Factors associated with mortality were those described in the general population, such as older age and being on corticosteroids and CD20 inhibitors treatment at COVID-19 diagnosis.

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Table 1. Clinical and demographic characteristics of patients with rheumatic diseases and COVID-19 in Mexico and mortality.

Characteristics at COVID-19 diagnosis	Total N=323	Death 43 (13.3)	Survivors 280 (86.7)	Univariable OR (95% CI)	Multivariable OR (95% CI)
Women, n(%)	268 (82.9)	33 (76.7)	235 (83.9)	0.6 (0.3-1.4)	0.5 (0.2-1.3)
Age >65 years old, n(%)	62 (19.2)	18 (41.9)	44 (15.7)	3.9 (1.9-7.7)	3.9 (1.9-8.3)
RMDs* n(%)					
Rheumatoid arthritis	149 (46.1)	23 (53.5)	126 (45.0)	1.6 (0.7-3.7)	-
Systemic Lupus Erythematosus	64 (19.8)	10 (23.3)	54 (19.3)	1.6 (0.6-4.3)	-
Spondyloarthritis (axial and others)	33 (10.2)	2 (4.7)	31 (11.1)	0.1 (0.1-2.8)	-
Others	77 (23.8)	8 (18.6)	69 (24.6)	1	-
Moderate/High disease activity ¹ , n(%)	57 (18.6)	7 (17.9)	50 (18.7)	1.0 (0.4-2.5)	-
None comorbidities, n(%)	136 (42.1)	8 (18.6)	128 (45.7)	0.3 (0.1-0.6)	-
Hypertension*, n(%)	88 (27.2)	12 (27.9)	76 (27.1)	1.0 (0.5-2.1)	-
Type 2 Diabetes*, n(%)	49 (15.2)	13 (30.2)	36 (12.9)	2.9 (1.4-6.1)	2.4 (1.1-5.4)
Obesity*, n(%)	21 (6.5)	3 (6.9)	18 (6.4)	1.1 (0.3-3.9)	-
Chronic obstructive pulmonary disease*, n(%)	15 (4.6)	1 (2.3)	14 (5.0)	0.5 (0.1-3.5)	-
Chronic renal insufficiency*, n(%)	17 (5.2)	6 (13.9)	11 (3.9)	3.9 (1.4-11.4)	3.4 (1.1-10.4)
Cardiovascular diseases*, n(%)	14 (4.3)	2 (4.7)	12 (4.3)	1.1 (0.2-5.0)	-
Corticosteroids*, n(%)	171 (52.9)	30 (69.7)	141 (50.3)	2.3 (1.1-4.5)	3.0 (1.4-6.5)
CsDMARD*, n(%)	247 (76.5)	33 (76.3)	214 (76.4)	1.0 (0.5-2.2)	-
CD20 inhibitor*, n(%)	21 (6.5)	7 (16.3)	14 (5.0)	3.7 (1.4-9.9)	4.9 (1.7-14.5)

*Overlapped, ¹ 307 patients.

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POS1243 TELEMEDICINE AND MANAGEMENT OF THE PATIENT AFFECTED BY GIANT CELL ARTERITIS DURING THE COVID-19 PANDEMIC - TELEMACOV

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Background: Giant cell arteritis (GCA) is the most common primary systemic vasculitis in western countries with the highest incidence among persons 70–79 years of age. Treatment has been with glucocorticoids (GCs) alone for many decades but recently Tocilizumab (TCZ) has demonstrated efficacy in reducing GC dose and flare rates in patients with GCA. Therefore, both early diagnosis and regular monitoring are necessary for the correct management of GCA. The COVID-19 pandemic has led to decisions by the governments of the countries involved, aimed above all at reducing the contagion. This has also led to reductions in health activities, limiting them to those of urgency by reducing or canceling checkups involving the risk of a time gap which for the GCA meant the interruption of clinical monitoring and therapeutic adjustment. At the same time, the pandemic situation has stimulated remote monitoring activities, through telephone contacts or video calls carried out by the rheumatologist. EULAR identified a minimal data set aimed at research and for clinical use, which includes the main clinical and instrumental data to be taken into consideration in monitoring the patient. For many data a clinical examination is not necessary but an interview is sufficient. We activated the TELEMACOV protocol (TELEmedicine and Management of the patient affected by giant cell arteritis during the COVID-19 pandemic) monitoring the follow-up of patients affected by GCA through telemedicine tools in order to maintain an effective and risk-free follow-up in a pathology with a high risk of relapse.

Objectives: The purpose of the study is to evaluate the effectiveness of telemedicine in the follow-up of the patient with GCA.

Methods: We evaluated patients (pts) with a clinical diagnosis of GCA (received in previous periods) who were admitted to the our Rheumatology Unit. They were monitored monthly by telephone from 9 March to 9 June 2020 (during lockdown). All patients were asked questions divided according to the sub-groups listed below:

- Onset of new symptoms or their recurrence
- Exams carried out
- Current therapy
- Satisfaction of telephone call

Results: We performed 148 remote monitoring visits in 37 pts. The cohort was mainly composed by female (77.8%) and had a mean age of 71.85 ± 9.25 years. They were affected by GCA, with a mean duration of 5.3±2.3 months. The characteristics of these pts and the course of the disease are reported in Table 1. Pts treated with TCZ reduced their GC dose more than patients treated with GC alone (p: 0.032). Only one patient (treated with GC alone) had an ocular flare with the need to increase the dosage of the GC with good response and rapid

improvement. Furthermore, all patients considered this type of monitoring very satisfactory according to the Likert scale (1-5) with mean 4.4±0.2.

Conclusion: Our study has shown how telemedicine can be well used in pts with GCA as a possible alternative, for a limited period, to traditional visits, especially in a fragile population such as the elderly and more exposed to the risk of SARS-CoV2 infection.

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Table 1. Disease course and remote monitoring

Parameters	Baseline (at diagnosis)		Pre-lock down	SD	First Interview		Second Interview	
	Mean	SD			Mean	SD	Mean	SD
Patients treated with only GC (19 pts)								
ESR	74,08	23,95	13,02	8,2	12,75	6,42	9,84	6,63
CRP mg/l	47,4	42,2	1,01	1,1	1,55	2,29	1,56	2,24
Hgb mg/dl	11,6	2,6	13,2	2,24	12,75	3,19	13,58	2,12
PGA (1-10)	7,55	2,05	2,71	1,79	2,24	1,59	2,15	1,04
EGA (1-10)	6,99	1,85	2,19	1,42	1,97	1,13	1,43	0,97
GC mg	52,72	18,3	10,1	6,95	7,6	4,51	6,67	3,1
Patients treated with GC and TCZ (18 pt)								
ESR	74,56	36,58	11,3	3,85	9,89	4,71	3,37	4,4
CRP mg/l	47,8	41,7	1,13	0,65	1,58	0,85	1,62	0,73
Hgb mg/dl	11,36	3,88	12,98	4,91	12,43	4,3	13,25	5,15
PGA (1-10)	7,14	3,11	2,47	2,15	1,89	0,4	1,93	0,72
EGA (1-10)	6,93	2,72	0,95	0,73	0,68	0,43	0,41	0,72
GC mg	51,76	18,85	8,04	4,38	5,88	3,92	4,16	4,32

PGA: Patient Global Assessment EGA: Evaluator Global Assessment;

Disclosure of Interests: None declared

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POS1244

PRELIMINARY RESULTS OF LONG-TERM FOLLOW-UP OF THE HEALTH STATUS OF PATIENTS USING CSDMARDS AND B/TSDMARDS FOR RHEUMATIC DISEASES DURING THE COVID-19 PANDEMIC

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Background: Since its inception, the COVID-19 outbreak has been carefully monitored both by the patients using DMARDS and their physicians. There is no data that patients with rheumatic and musculoskeletal diseases (RMD) are at a higher risk of contracting COVID-19 disease than those without RMD (1). COVID-19-related death in people with RMD has been associated with older

Table 1. Patient characteristics

	All Patients n=160	COVID-19 Patients n=24
Male	61 (38%)	6 (25%)
Female	99 (62%)	18 (75%)
Mean age	49.5	49.5
Ever smoker	88 (55%)	8 (33,3%)
Obesity	51 (32%)	9 (37,5%)
Hypertension (HT)	46 (29%)	7 (29%)
Diabetes (DM)	22 (14%)	2 (8%)
Cardiovascular disease (CVD)	26 (16%)	5 (20%)
Chronic lung disease (CLD)	12 (7,5%)	4 (16%)
SpA	71 (44,3%)	9 (37,5%)
RA	71 (44,3%)	14 (58,3%)
PsA	14 (8,8%)	1 (4,2%)
SLE	2 (1,25%)	-
PMR	2 (1,25%)	-
cDMARD only	82 (51,2%)	14 (58,3%)
b/tsDMARD only	55 (34,4%)	8 (33,3%)
Combined DMARD	23 (14,4%)	2 (8,4%)

The rate of getting COVID-19 infection was 15% in all patients. This rate was 18% in all obese patients, 19% in those with at least one comorbid disease (HT, DM, CVD, CLD), and 22% in those who were obese and had at least one comorbid disease. 16% of non-smokers and 9% of those who ever smoked got COVID-19. Among patients over the age of 65 (n=17), 2 patients (%12) had COVID-19. Treatments of RMDs of patients with COVID-19 were as follows: bDMARD=8 [(Etanercept(ETN) n=2, adalimumab (ADA) n=2, certolizumab pegol (CTZ) n=1, infliximab (IFX) n=1, golimumab (GOL) n=1, RTX n=1)], csDMARD=14 [(methotrexate (MTX) n=4, leflunomid (LEF) n=4, SSZ n=3, HCQ n=2, MTX+SSZ+HCQ n=1)], combined=2 [tofacitinib (TOF)+MTX n=1, TCZ+LEF n=1)], none of them was using glucocorticoids. Overall 17% of patients using csDMARD, 14,5% of patients using b/tsDMARD as monotherapy and 9% of patients using combination treatment had COVID-19. Of the patients using HCQ (n=14), 3 (21%) were diagnosed with COVID-19 disease. 18 of the patients received COVID-19 treatment at home, 6 were hospitalized and 1 of them (RA patient, LEF user) needed intensive care unit. None of them died.

age, male gender, concomitant cardiovascular and pulmonary diseases, moderate/high disease activity, and certain treatments (rituximab (RTX), sulfasalazine (SSZ) and some immunosuppressants) (2).

Objectives: To determine the conditions of getting and being affected poorly by COVID-19 and related factors of RMD patients followed in our outpatient clinic.

Methods: 160 patients over 18 years of age who applied to our outpatient clinic between July 2020-January 2021; who used DMARDS for rheumatic diseases and agreed to participate were included in the study. The patients's demographic data, RMDs, csDMARDS and b/tsDMARDS usage, comorbid diseases and smoking status were recorded. The data of the patients on COVID-19 disease between March 2020 and January 2021 were questioned at each visit.

Results: Patient characteristics are presented in Table 1. 57 (36%) of all patients had COVID-19 PCR test, 23 (14%) were positive, and 1 patient was diagnosed with COVID-19 because the CT findings were positive, although the PCR test was negative.

Conclusion: Preliminary results regarding the health status associated with COVID-19 of our patients with RMD are presented. Biologic drugs seems not to increase COVID-19 but final results will be presented after the completion of statistical analysis of all data.

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POS1245

MORTALITY OF COVID-19 IN PATIENTS WITH RHEUMATIC DISEASES: COMPARISON TO THE GENERAL POPULATION IN MÉXICO

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Background: COVID-19 outcomes in Mexican patients with rheumatic diseases (RDs) in comparison to general population patients are unknown.

Objectives: To compare mortality and hospitalization of COVID-19 patients with RDs and those without.

Methods: We included for this study all the Mexican patients with RDs and COVID-19 registered from April 17th to October 30th, 2020 in the COVID-19 Global Rheumatology Alliance registry. We compare clinical and demographic characteristics of patients with RDs and COVID-19 to patients with COVID-19 that were selected randomly from the Mexican Epidemiology database (1:3). A logistic regression analysis was performed to adjust for confusion variables.

Results: We included 322 patients with COVID-19 and RDs and 969 controls without RDs. Table 1 shows the demographic characteristics and comorbidities of both groups. Bivariate analysis showed that patients with RDs had higher mortality, were older, and were more frequently hospitalized. Comorbidities, such as diabetes, hypertension, cardiovascular and renal diseases were also more frequent in patients with RDs. In the multivariate analysis, having a RD was no longer associated with mortality (Figure 1).