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.

REFERENCES:

- [1] Ehlers L et al. Ann Rheum Dis 2019 Sep;78(9):1160-1166
- [2] Wagner E et al. Prim Care. 2012 Jun;39(2):241-59.

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

DOI: 10.1136/annrheumdis-2021-eular.3357

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

F. Unlu Ozkan¹, K. Sari¹, I. Aktas¹. ¹University of Health Sciences Fatih Sultan Mehmet Training and Research Hospital, Physical Medicine and Rehabilitation, Istanbul, Turkey

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.

REFERENCES:

- [1] Landewé RB, Machado PM, Kroon F, et al. EULAR provisional recommendations for the management of rheumatic and musculoskeletal diseases in the context of SARS-CoV-2. Ann Rheum Dis. 2020;79(7):851-858. doi:10.1136/annrheumdis-2020-217877
- [2] Strangfeld A, Schäfer M, Gianfrancesco MA, et al. Factors associated with COVID-19-related death in people with rheumatic diseases: results from the COVID-19 Global Rheumatology Alliance physician-reported registry [published online ahead of print, 2021 Jan 27]. Ann Rheum Dis. 2021;annrheumdis-2020-219498. doi:10.1136/annrheumdis-2020-219498

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.3445

POS1245

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

M. U. Martínez-Martínez¹, F. Irazoque-Palazuelos², T. S. Rodríguez-Reyne³, E. Zamora⁴, A. Castillo Ortiz⁵, B. E. Zazueta⁶, S. Duran Barragan⁷, M. Rull-Gabayet⁸, J. F. Moctezuma-Ríos⁸, X. Jimenez Jimenez⁹, E. Martin-Nares³, D. Cervantes-Rosete³, D. Vega-Morales¹⁰, D. X. Xibille Friedmann¹¹, A. Barragán-Garfías⁹, E. Alvarez Hernandez⁸, M. Vázquez-Del Mercado Espinosa¹², C. F. Pacheco Tena¹³, D. Alpizar-Rodriguez¹⁴ on behalf of Mexican Study group of COVID-19 in Rheumatic diseases. ¹Instituto Mexicano del Seguro Social, Internal Medicine, Rioverde, Mexico; ²Centro de Investigación y Tratamiento Reumatológico S.C., Rheumatology, Mexico City, Mexico; ³Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubiran, Immunology and Rheumatology, Mexico City, Mexico; ⁴Centro Médico de Pensiones, Rheumatology, Merida, Mexico; ⁵Private Practice, Rheumatology, Merida, Mexico; ⁶Private Practice, Rheumatology, Mexicali, Mexico; ⁷Clínica de Investigación en Reumatología y Obesidad, Rheumatology, Guadalajara, Mexico; ⁸Hospital General de México "Dr. Eduardo Liceaga", Rheumatology, Mexico City, Mexico; ⁹Private Practice, Rheumatology, Mexico City, Mexico; ¹⁰Private Practice, Rheumatology, Monterrey, Mexico; ¹¹Servicios de Salud de Morelos, Departamento de Investigación y Capacitación, Cuernavaca, Mexico; ¹²Hospital Civil de Guadalajara "Juan I. Menchaca", Rheumatology, Guadalajara, Mexico; ¹³Facultad de Medicina y Ciencias Biomédicas, Rheumatology, Chihuahua, Mexico; ¹⁴Colegio Mexicano de Reumatología, Research Unit, Mexico City, Mexico

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).

Table 1. Comparison of patients with COVID-19 with and without RDs

	COVID-19 patients without RDs	COVID-19 patients with RDs	p-value
N	969	323	
Age (mean (SD))	42.6 (17.4)	51.2 (13.9)	<0.001
Sex = Male (%)	455 (47.0)	55 (17.0)	<0.001
Deceased = Yes (%)	55 (5.7)	43 (13.3)	<0.001
Hospitalization = Hospitalized (%)	164 (16.9)	152 (47.1)	<0.001
Intubation = Yes (%)	27 (2.8)	32 (11.8)	<0.001
COPD_Asthma = Yes (%)	37 (3.8)	15 (4.6)	0.522
Diabetes = Yes (%)	114 (11.8)	49 (15.2)	0.116
Obesity = Yes (%)	128 (13.3)	21 (6.5)	0.001
Hypertension = Yes (%)	152 (15.8)	88 (27.2)	<0.001
Cardiovascular disease = Yes (%)	19 (2.0)	14 (4.3)	0.02
CRF = Yes (%)	22 (2.3)	17 (5.3)	0.007
Pregnancy = Yes (%)	5 (0.5)	2 (0.6)	0.827
Smoker = Yes (%)	86 (8.9)	10 (3.1)	0.001

Abbreviations: RDs, rheumatic diseases; COPD, chronic obstructive pulmonary disease; CRF, chronic renal failure.

Variable	N	Odds ratio	p
Age	1236	1.05 (1.03, 1.07)	<0.001
Hospitalization			
ambulatory	971	Reference	
Hospitalized	265	14.48 (7.19, 31.79)	<0.001
Intubation			
No	1177	Reference	
Yes	59	9.67 (4.77, 20.60)	<0.001
Diabetes			
No	1078	Reference	
Yes	158	1.44 (0.74, 2.74)	0.27
Hypertension			
No	1012	Reference	
Yes	224	0.95 (0.49, 1.78)	0.87
CRF			
No	1199	Reference	
Yes	37	1.70 (0.64, 4.36)	0.27
Smoker			
No	1140	Reference	
Yes	96	0.17 (0.02, 0.86)	0.05
RD			
No	964	Reference	
Yes	272	1.13 (0.62, 2.01)	0.68

Figure 1. Multivariate analysis of mortality

Conclusion: Patients with RDs had higher comorbidities, hospitalizations, and mortality than the general population in the bivariate analysis. However, adjusted multivariate analysis showed that the odds for mortality were not increased because of having a RD. These findings suggest that the increased mortality of Mexican patients with RDs may be explained by the higher frequency of comorbidities in this population.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.3447

POS1246 COVID-19 IN ITALIAN PATIENTS WITH RHEUMATIC AUTOIMMUNE SYSTEMIC DISEASES: RESULTS OF A NATIONWIDE SURVEY STUDY

C. Ferri¹, D. Giuggioli², V. Raimondo³, L. Dagna⁴, V. Ricciari⁵, E. Zanatta⁶, S. Guiducci⁷, A. Tavoni⁸, R. Foti⁹, G. Cuomo¹⁰, R. De Angelis¹¹, F. Cozzi¹², G. Murdaca¹³, I. Cavazzana¹⁴, N. Romeo¹⁵, V. Codullo¹⁶, F. Ingegnoli¹⁷, R. Pellegrini¹⁸, M. Varcasia¹⁹, A. Della Rossa²⁰, M. De Santis²¹, G. Abignano²², M. Colaci²³, M. Caminiti²⁴, M. L'andolina²⁵, E. Lubrano²⁶, A. Spinella², F. Lumetti², G. De Luca⁴, S. Bellando Randone⁷, E. Visalli⁹, S. Bilia⁸, F. Masini¹⁰, G. Pellegrino¹², E. Pigatto¹², E. Generali²¹, F. Franceschini¹⁴, G. Pagano Mariano²⁴, S. Barsotti²⁰, G. Pettiti¹⁵, G. Zanfrumando¹⁶, R. Britelli²⁷, V. Aiello²⁷, D. Scorpiniti²⁷, T. Ferrari¹⁹, R. Caminiti²⁷, C. Campochiaro⁴, P. Gigliotti²⁸, R. Cecchetti²⁹, D. Olivo³⁰, F. Ursini³¹, V. Brusi³¹, R. Meliconi³¹, F. Caso³², R. Scarpa³², S. D'angelo²², F. Iannone³³, M. Matucci-Cerinic⁷, A. Doria⁶, M. Miccoli³⁴, S. R. Paparo³⁵, F. Ragusa³⁴, G. Elia³⁴, S. M. Ferrari³⁴, P. Fallahi³⁶, A. Antonelli³⁷. ¹Rheumatology Unit, University of Modena & RE., School of Medicine, Modena, Italy; ²Rheumatology Clinic 'Madonna dello Scoglio' Cotronei, Crotone, Italy; ³Rheumatology Department, Modena; ⁴Cotronei, Italy; ⁵Rheumatology Unit, University of Modena & RE., School of Medicine, Modena, Italy; ⁶Rheumatology Department, Modena, Italy; ⁷Rheumatology Clinic 'Madonna dello Scoglio' Cotronei, Crotone, Italy; ⁸Rheumatology Department, Modena; ⁹Rheumatology Clinic 'Madonna dello Scoglio' Cotronei, Crotone, Italy; ¹⁰Ospedale S. Raffaele, Milano, Italy; ¹¹Rheumatology Department, Milano, Italy; ¹²Rheumatology, Sapienza-University of Rome, Italy;

Rheumatology Department, Roma, Italy; ¹³Rheumatology, University of Padova, Italy; ¹⁴Rheumatology Department, Padova, Italy; ¹⁵Rheumatology, University of Florence, Italy; ¹⁶Rheumatology Department, Firenze, Italy; ¹⁷Clinical Immunology, University of Pisa, Pisa, Italy; ¹⁸Immunology, Pisa, Italy; ¹⁹AOU Policlinico Vittorio Emanuele, Catania, Italy; ²⁰Rheumatology Department, Catania, Italy; ²¹University of Campania, Luigi Vanvitelli, Napoli, Italy; ²²Rheumatology Department, Napoli, Italy; ²³Rheumatology Clinic, Marche Polytechnic University, Ancona, Italy; ²⁴Dpt Clinical & Molecular Sciences, Ancona, Italy; ²⁵Ospedale "Villa Salus" Mestre, Italy; ²⁶Rheumatology Department, Mestre, Italy; ²⁷Ospedale Policlinico S. Martino-University of Genova, Italy; ²⁸Rheumatology Department, Genova, Italy; ²⁹Rheumatology, Spedali Civili di Brescia, Italy; ³⁰Rheumatology Department, Brescia, Italy; ³¹ASO S. Croce e Carle, Cuneo, Italy; ³²Rheumatology Department, Cuneo, Italy; ³³Rheumatology, Policlinico San Matteo, Pavia, Italy; ³⁴Rheumatology Department, Pavia, Italy; ³⁵Rheumatology, University of Milano, Italy; ³⁶Rheumatology Department, Milano, Italy; ³⁷U.O.C. Medicina Interna "M. Valentini" P.O. Annunziata Cosenza, Italy; ³⁸Medicine, Cosenza, Italy; ³⁹U.O.S. Reumatologia, Ospedale Castrovillari, Cosenza, Italy; ⁴⁰Rheumatology Department, Castrovillari, Italy; ⁴¹Rheumatology, University of Pisa, Pisa, Italy; ⁴²Rheumatology Department, Pisa, Italy; ⁴³Istituto Clinico Humanitas, Rozzano, Milano, Italy; ⁴⁴Rheumatology Department, Milano, Italy; ⁴⁵AOR San Carlo di Potenza, Potenza, Italy; ⁴⁶Rheumatology Department, Potenza, Italy; ⁴⁷Rheumatology, University of Catania, Catania, Italy; ⁴⁸Rheumatology Department, Catania, Italy; ⁴⁹UOD Reumatologia - Grande Ospedale Metropolitano, Reggio Calabria, Italy; ⁵⁰Rheumatology Department, Reggio Calabria, Italy; ⁵¹Rheumatology Outpatient Clinic, ASP - Vibo Valentia-Tropea Hospital, Italy; ⁵²Rheumatology Department, Tropea, Italy; ⁵³Rheumatology, Università del Molise, Campobasso, Italy; ⁵⁴Rheumatology Department, Campobasso, Italy; ⁵⁵Rheumatology Clinic 'Madonna dello Scoglio' Cotronei, Crotone, Italy; ⁵⁶Rheumatology Department, Cotronei, Italy; ⁵⁷U.O.T. Specialistica Ambulatoriale ASP 201, Cosenza, Italy; ⁵⁸Rheumatology Department, Cosenza, Italy; ⁵⁹Ospedale di Portoferraio, Livorno, Italy; ⁶⁰Rheumatology Department, Livorno, Italy; ⁶¹Rheumatology Outpatient Clinic, San Giovanni di Dio Hospital, Crotone, Italy; ⁶²Rheumatology Department, Crotone, Italy; ⁶³University of Bologna, Rizzoli Orthopaedic Institute Bologna, Bologna, Italy; ⁶⁴Rheumatology Department, Bologna, Italy; ⁶⁵Rheumatology Unit, Department of Clinical Medicine and Surgery, University of Naples Federico II, Naples, Italy; ⁶⁶Rheumatology Department, Napoli, Italy; ⁶⁷UO Reumatologia - DETO, Università di Bari, Italy; ⁶⁸Rheumatology Department, Bari, Italy; ⁶⁹University of Pisa, School of Medicine, Pisa, Italy; ⁷⁰Department of Clinical and Experimental Medicine, Pisa, Italy; ⁷¹University of Pisa, School of Medicine, Pisa, Italy; ⁷²Department of Translational Research & New Technologies in Medicine and Surgery, Pisa, Italy; ⁷³University of Pisa, School of Medicine, Pisa, Italy; ⁷⁴Translational Research and New Technologies in Medicine and Surgery, Pisa, Italy; ⁷⁵University of Pisa, School of Medicine, Pisa, Italy; ⁷⁶Clinical and Experimental Medicine, Pisa, Italy

Background: SARS-CoV-2 infection poses a serious challenge for patients with rheumatic autoimmune systemic diseases (ASD), characterized by marked immune-system dysregulation and frequent visceral organ involvement.

Objectives: To evaluate the impact of Covid-19 pandemic in a large series of Italian patients with ASD.

Methods: Our multicenter telephone survey (8-week period, March-April 2020) included a large series of 2,994 patients (584 M, 2,410 F, mean age 58.9±13.4SD years) with ASD followed at 34 tertiary referral centers of 14 regions of northern, central, and southern Italian macro areas, characterized by different prevalence of SARS-CoV-2 infection. According to currently used criteria, Covid-19 was classified as *definite* Covid-19 (signs or symptoms of Covid-19 confirmed by positive oral/nasopharyngeal swabs at PCR testing) or *highly suspected* Covid-19 (signs or symptoms highly suggestive of Covid-19, but not confirmed by PCR testing due to limited availability of virological tests in that period). The results were analyzed performing the Odds Ratio by Java-Stat 2-way Contingency Table Analysis.

Results: The main findings of the survey study revealed a significantly increased prevalence of Covid-19 in: a. the whole series of ASD patients (*definite* Covid-19: 22/2994, 0.73%; p=0.0007; *definite* Covid-19 plus *highly suspected* Covid-19: 74/2,994, 2.47%; p<0.0001) when compared to Italian general population of Covid-19 infected individuals (349/100000 = 0.34%; data from Italian Superior Institute of Health; <https://www.epicentro.iss.it/en/coronavirus/sars-cov-2-national-surveillance-system>).

b. the subgroup of patients with connective tissue diseases or systemic vasculitis (n = 1,901) compared to the subgroup of inflammatory arthritis (n = 1,093), namely rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis (*definite* Covid-19: 19/1,901, 0.99%, vs 3/1,093, 0.27%; p=0.036; *definite* Covid-19 plus *highly suspected* Covid-19: 69/1,901, 3.6%, vs 5/1,093, 0.45%; p<0.0001).

c. the subgroup of patients with pre-existing interstitial lung involvement (n = 526) compared to those without (n = 2,468) (*definite* Covid-19: 10/526, 1.90%, vs 12/2,468, 0.48%; p=0.0015; *definite* Covid-19 plus *highly suspected* Covid-19: 33/526, 6.27%, vs 41/2,468, 1.66%; p<0.0001).