

Table 1.

Clinical endpoint	Normalized protein catabolic ratio	P	Serum albumin	P	Lean tissue index	P
With peritonitis	0.85 (IQR 0.73–1.05)	ns	3.7 (IQR 3.3–4)	ns	13.7 (IQR 11.9–16.2)	ns
Without peritonitis	0.84 (IQR 0.73–1.05)		3.7 (IQR 3.3–3.7)		13.8 (IQR 12–16.3)	
With hospital admissions	0.86 (IQR 0.75–1.06)	ns	3.6 (3.2–4)	ns	13.6 (IQR 13.6–15.3)	ns
Without hospital admissions	0.85 (IQR 0.72–1.05)		3.7 (IQR 3.3–4)		13.7 (IQR 12–16.2)	
With PD failure	0.86 (IQR 0.75–1.07)	ns	3.7 (IQR 3.3–4.1)	ns	13.8 (IQR 12.4–16.3)	ns
Without PD failure	0.85 (IQR 0.73–1.05)		3.7 (IQR 3.3–4)		13.7 (IQR 12–16.2)	

Use of ACE and ARB without statins resulted in D/P creatinine 0.64 ($n = 54$), whereas use of statins alone in D/P creatinine 0.63 ($n = 48$). The difference between groups was statistically not significant. There was a tendency of higher values of D/P creatinine (median 0.68) in patients under therapy with ACE and statins (Fig. A). sCRP was higher in patients without ACE, ARB and statins compared to patients with ACE, ARB or statins (0.60 versus 0.30 mg/dL, $P < 0.05$) (Fig. B). Furthermore platelet count was slightly higher in patients without ACE, ARB and statins (25 8000 versus 22 6000/mm³). Blood leukocyte count did not present significant differences (median values 6930 to 6855/mm³).

CONCLUSION: Our data suppose the absence of a protective effect of ACE, ARB and statins on peritoneal transport expressed by P/D creatinine despite reduced signs of systemic inflammation.

MO671 SHOULD WE UNDERGO PERITONEAL DIALYSIS IN MALNOURISHED CHRONIC KIDNEY DISEASE PATIENTS?

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BACKGROUND AND AIMS: The implementation of peritoneal dialysis (PD) in end-stage renal disease has been associated with various long-term pathophysiological changes, which result in adverse consequences, such as malnutrition, occurring in 30–50% of patients. Specific factors to PD might be associated with poor oral intake as continuous absorption of glucose from PD solutions and abdominal fullness induced by the dialysate can suppress appetite.

There are several accepted strategies for stratifying malnutrition in PD, such as laboratory markers [serum albumin and normalized protein catabolic ratio (nPCR)] and the recent use of bioimpedance spectroscopy (BIS) (with low lean tissue index). We aimed to evaluate if PD patients with a poor nutritional status at the beginning of the technique had worse outcomes (peritonitis, PD failure, hospitalizations, and death). **METHOD:** We studied a cohort of incident patients from a single PD unit between 1 July 2011 and 31 August 2021, who had one BIS measurement and a peritoneal equilibration test in the first 3 months after the start of PD. We also collect laboratory data within 6 months from the BIS evaluation (serum albumin). Besides demographic parameters, we evaluated established endpoints (peritonitis, PD failure, hospitalizations and death).

RESULTS: There were included 91 PD patients. The mean age of patients was 65.40 ± 13.88 years with a median dialysis vintage of 24 (IQR 14–31.61) months; 59.3% were male and 28% had diabetes. During the follow-up period, 5.5% of the cohort died, 56% were hospitalized and 47.3% had at least one episode of peritonitis. Furthermore, the transfer to hemodialysis occurred in 18 cases (19.8%) and 15 (16.5%) received a renal transplant.

There was no difference in nutritional markers median in patients that had clinical endpoints *versus* those who had not (Table 1). In a multivariable analysis, neither nPCR, nor albumin nor lean tissue index were predictors of peritonitis, PD failure or hospital admissions.

CONCLUSION: In this study, we found that malnourished patients, prevalent in PD, did not have worse clinical endpoints (higher rate of infections, hospital admissions and PD failure). Although adequate nutrition has been deemed vital to the success of PD, this modality of renal replacement therapy did not result in worse outcomes, despite the malnutrition markers at the beginning of PD. Further studies are warranted to evaluate the positive impact of PD in nutrition status.

MO672 COVID-19 IN PATIENTS ON PERITONEAL DIALYSIS: A CASE-SERIES

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BACKGROUND AND AIMS: A great amount of information has been divulged on the epidemiology and outcome of coronavirus disease 2019 (COVID-19) in patients with ESRD. The majority of the studies have been conducted in patients on maintenance hemodialysis (HD) and kidney transplant recipients. Unfortunately, few studies focused on the outcome of peritoneal dialysis (PD) patients. Information regarding this subset of the population has been extrapolated from aggregated data including a higher percentage of HD patients. As a result, the impact of COVID-19 is indefinite in patients receiving PD. We conducted a study to better understand how patients on PD have been affected by COVID-19.

METHOD: We conducted a single-center retrospective analysis of 141 PD patients followed at the University Hospital of Modena, Italy from 1 March 2020 to 31 December 2021. The diagnosis of COVID-19 was performed through nasopharyngeal swab RT-PCR testing. Duration of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) shedding measured the time elapsed from diagnosis of COVID-19 to one or two (if available) negative nasopharyngeal PCR tests. Median and interquartile range or mean and standard deviation were used for continuous variables and percentage for categorical variables. A P-value <0.05 was considered statistically significant.

RESULTS: During the pandemic, 18 out of 141 (12.7%) patients receiving PD dialysis contracted COVID-19. Median age was 60 (50.2–66.5) years with a predominance of males (72.2%)

The percentage of patients on APD accounted for 33.3%.

The infection was symptomatic in out of 18 (94.4%) patients. Fever (94.4%) and cough (55.6%) were the most common symptoms. Viral shedding, traced with nasopharyngeal swabs lasted 26 (14.5–3.5) days. Two patients were inactive on the waiting list for kidney transplantation for a mean of 43 ± 1.4 days.

COVID-19 caused hospital admission of seven (38.9%) patients. During hospitalization two (11.1%) patients switched from PD to HD for ultrafiltration failure and inadequate solute clearance and two (11.1%) died for septic shock with multiorgan failure. In our cohort of patients, excess death due to COVID-19 was 22.2%.

Half of the patients contracted the infection before the availability of SARS-CoV-2 vaccine. There were no statistically significant differences between vaccinated and unvaccinated patients in terms of symptoms, viral shedding and hospital admission or (Table 1). We underline that COVID-19 was fatal only in two unvaccinated patients.

CONCLUSION: This study reports the monocentric experience of a large PD center during the COVID-19 pandemic. COVID-19 was symptomatic in the majority of patients and led to hospitalization of about 40% of the patients. The rate of symptoms, viral shedding and hospital admission was similar between vaccinated and unvaccinated patients. Two unvaccinated patients died for the severe consequence of COVID-19.

MO673 ASSOCIATION OF MEAN CORPUSCULAR VOLUME WITH MORTALITY IN KIDNEY FAILURE PATIENTS: OPPOSITE FINDINGS IN CHINESE AND SWEDISH KIDNEY FAILURE PATIENTS

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BACKGROUND AND AIMS: Higher mean corpuscular volume (MCV), a measure of the average size of the circulating erythrocyte used for differential diagnosis of anemia or for monitoring macrocytosis, is associated with higher mortality in various clinical settings including in patients (pts) with kidney failure; however, results are not consistent and a study from Japan (Honda et al. Low rather than high mean corpuscular volume is associated with mortality in Japanese patients under hemodialysis. *Sci Rep.* 2020; **10**(1): 15 663) found that low MCV associated with mortality in 8571 hemodialysis pts (mean age 62.5 ± 12.7 years, 37.2% female, median