Table 1.

	1st wave, n= 32	2nd wave, n=45	3rd wave, n=23	4th wave, n=4	5th wave, n=26	p-value	6th wave, n=30 (until 5th January 2022)
Infected KT and incidence (n, %)	32 (32/842, 3.8%)	45 (45/903, 4.9%)	23 (23/913, 2.5%)	4 (4/941, 0.4%)	26 (26/967, 2.6%)		30 (30/969, 3.1%)
COVID-19 vaccination						**<0.001**	
Complete	0 (0%)	0 (0%)	0 (0%)	4 (100%)	24 (92.3%)		29 (96.7%)
- *Pfizer*				*- 0 (0%)*	*- 5 (20.8%)*		*- 6 (20.7%)*
- *Moderna*				*- 4 (100%)*	*- 19 (79.2%)*		*- 22 (75.9%)*
- *AstraZeneca*				*- 0 (0%)*	*- 0 (0%)*		*- 1 (3.4%)*
Partial	0 (0%)	0 (0%)	3 (13.0%)	0 (0%)	1 (3.8%)		0 (0%)
Recipient gender (female) (n, %)	12 (37.5%)	15 (33.3%)	3 (13.0%)	1 (25.0%)	11 (42.3%)	0.190	14 (46.7%)
Recipient age (years) [mean (SD)]	67.4 (10.1)	61.2 (11.7)	54.3 (15.1)	49.8 (10.2)	62.7 (12.1)	**<0.001**	58.9 (14.8)
Time after KT (months) [median (IQR)]	46.5 [12.7-116.4]	75.6 [27.1-111.4]	86.6 [38.2-118.1]	29.7 [17.4-50.0]	55.2 [28.5-112.3]	0.314	41.3 [16.3-133.9]
Asymptomatic infection (n, %)	2 (6.3%)	7 (15.6%)	4 (17.4%)	0 (0%)	0 (0%)	0.135	0 (0%)
Fever (n, %)	24 (77.4%)	27 (60.0%)	16 (69.6%)	2 (50.0%)	18 (69.2%)	0.513	
Respiratory symptoms (n, %)	22 (73.3%)	26 (59.1%)	11 (47.8%)	3 (75.0%)	20 (76.9%)	0.176	
Gastrointestinal symptoms (n, %)	14 (45.2%)	12 (27.3%)	7 (30.4%)	1 (25.0%)	11 (42.3%)	0.474	
Pneumonia (n, %)	24 (80.0%)	24 (53.3%)	12 (52.2%)	2 (50.0%)	20 (76.9%)	**0.045**	
Hospital admission (n, %)	28 (87.5%)	25 (55.6%)	14 (60.9%)	3 (75.0%)	21 (80.8%)	**0.016**	
ICU admission (n, %)	7 (25.9%)	9 (37.5%)	2 (14.3%)	1 (33.3%)	9 (42.9%)	0.371	
Time of admission [median (IQR)]	11 [5-19]	18 [14-26]	11 [7-21]	11 [7-49]	16 [8-38]	0.092	
Endotracheal intubation (n, %)	9 (33.3%)	5 (20.8%)	2 (14.3%)	1 (33.3%)	8 (38.1%)	0.450	
Treatment: Tocilizumab (n, %)	7 (22.6%)	3 (6.7%)	2 (8.7%)	0 (0%)	3 (11.5%)	0.320	
Exitus (n, %)	12 (37.5%)	5 (11.1%)	2 (8.7%)	0 (0%)	4 (16.0%)	**0.033**	
Exitus / admitted patients (n, %)	12 (42.9%)	5 (20.0%)	2 (14.3%)	0 (0%)	4 (20.0%)	0.180	
Exitus / ICU admitted patients (n, %)	3 (42.9%)	4 (44.4%)	1 (50.0%)	0 (0%)	3 (37.5%)	1.000	

Table 1. Basal and epidemiologic characteristics of KT recipients with COVID-19 infection according to the epidemic wave of infection. One patient Corresponding to the 5th wave was pending of outcome at the closing of the analysis. Complete vaccination = 2 doses (2º dose >14 days before infection). Partial vaccination = 1 dose or 2 doses if 2º dose <14 days before infection.

MO992 IS IT SAFE TO RECEIVE KIDNEYS FROM DECEASED KIDNEY DONORS WHO TESTED POSITIVE FOR COVID-19 INFECTION?

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BACKGROUND AND AIMS: Our modern world is facing extraordinary circumstances while passing through a serious pandemic caused by the novel coronavirus (COVID-19) which may lead to multi-organ system failure and death. COVID-19 deaths may provide a potential source for kidneys available for transplantation. In our study, we are discussing the safety of receiving kidneys from donors who tested positive for the novel coronavirus.
METHOD: All renal transplant recipients registered in UNOS database who had their transplants between 1 March 2020 and 1 June 2021 were retrospectively reviewed. Patients who received kidney transplants from a deceased donor with positive PCR of COVID-19 test were included in our study. Patients were followed up till 1 July 2021. Data about recipient factors (age, sex, ethnicity, diabetes and date of renal transplant), transplant factors (type of induction therapy, maintenance immunosuppressive therapy, delayed graft functions, early post-operative rejection episodes, HLA mismatch, PRA level and cold ischemia time) and donor factors (age, sex, ethnicity, diabetes, hypertension, date of COVID-19 test and type of COVID-19 test) were collected. Outcome measured were post-transplant hospitalisation, acute rejection, delayed graft function, patient, and graft survival till the end of the follow-up.
RESULTS: Eighty-six transplant patients received kidneys from deceased donors who tested positive for COVID-19 infection using PCR test. Sixty patients received kidneys from deceased patients who tested positive for COVID-19 within 30 days pre-transplant. Twenty-six patients received kidneys from deceased patients who tested positive for COVID-19 between 30 and 90 days pre-transplant. Number of post-transplant hospitalisation and acute rejection episodes were nil. 19.76% of the patients had delayed graft functions. Graft loss occurred in one patient due to graft vein thrombosis. Patient survival was 100%.
CONCLUSION: Receiving kidneys from deceased donors who tested positive for COVID-19 infection seems safe and does not affect hospitalisation, acute rejection rates, graft or patient survival. Longer follow-up is needed to confirm our results.

MO993 INCIDENCE OF PTLD AND ITS RELATIONSHIP WITH CMV-SEROSTATUS POSITIVITY AMONG CHILDHOOD AND ADULTHOOD POPULATION: A REGISTRY DATA STUDY

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BACKGROUND AND AIMS: It is unknown how the epidemiology of post-transplant lymphoproliferative disease (PTLD) and its relationship with CMV infection differ between adult and pediatric kidney transplant recipients. In addition, with current advancements in immunosuppressive therapy, the incidence of PTLD has changed dramatically. The aim of our study is to elucidate the relationship between PTLD and CMV infection. Moerover, to assess the incidence of PTLD among Adult and pediatric renal transplant patients in the current era.
METHOD: All renal transplant patients registered in the Organ Procurement and Transplantation Network between 2005 and 2019 were retrospectively reviewed. Patient were followed up till December 2020. Patients who had multiple organ transplant or those with previous renal transplants were excluded from the study. Data about recipient factors (age, sex ethnicity, diabetes, CMV serostatus, and EBV serostatus), donor factors (living or deceased), transplant factors (PRA, Cold ischemia time, HLA mismatches, induction and immunosuppressive therapy) were reviewed. Incidence rate of PTLD at one year and five years post-transplant were calculated among the Adult and Pediatric population. Univariate and Multivariate cox-hazard regression models were performed to assess the relationship between CMV serostatus and occurrence of PTLD.
RESULTS: About 10 947 pediatric renal transplant patients were included. About 315 pediatric patients developed PTLD during the follow-up time (2.88%). About 50.55% of PTLD occurred within the first-year post-transplant. 60% occurred within two-year post-transplant, while 80.63% of them occurred within five years post-transplant. CMV recipient infection was not associated with PTLD occurrence in the pediatric population (HR = 0.88, Pvalue = 0.81, 95% confidence interval ranged between 0.66 and 1.18). Proportional hazard assumption was not violated with P = 0.55. Among the adult population, 1990/277 955 developed PTLD (0.77%). About 25.77% of PTLD among the adult population occurred within the first-year post-transplant. About 39.39% of PTLD in the adult occurred within two-year post-transplant. About 66.55%