Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

abnormal distribution the Mann-Whitney U test or Wilcoxon test was used.

Table1. Characteristics of patients with CKD and AKI with Covid 19

Variable†	Total n= 47	Chronic DP n= 29	AKI n= 18	Valor p
Years, age, median, (IQR)	59 (48-68)	57.0 (44.0-66.0)	63.5 (53.7-70.2)	0.11
Male, n, (%)	30 (63.8)	20 (69.0)	10 (55.6)	0.37
CKD diagnosis, years, median, (IQR)	2 (0-5)	4.0 (3.0-6.0)	1.0 (0.0-1.0)	<0.01
Hospital stay, days, median, (IQR)	9 (5-15)	7.0 (5.0-14.0)	10.5 (5.7-16.5)	0.51
SOFA, points, median (IQR)	7 (6-10)	7.0 (6.0-8.0)	7.5 (6.0-12.0)	0.66
APACHE, points, median (IQR)	18 (14-22)	16.0 (12.0-19.0)	20.0 (16.2-25.0)	0.03
D Dimer	672 (468-970)	579.0 (404.5-1991.0)	720.0 (475.0-951.0)	0.42
Lymphocytes	0.62 (0.45-0.93)	0.66 (0.49-0.93)	0.53 (0.38-0.75)	0.51
Platelets	210 (142-285)	210.0 (127.0-271.5)	212.5 (162.5-339.2)	0.38
Procalcitonin	1.37 (0.47-4.55)	2.56 (1.32-5.15)	0.53 (0.20-0.96)	<0.01
Ferritin	1244 (531.1-2851.1)	1233.7 (486.3-4019.5)	1244.0 (548.6-1728.8)	0.35
PCR	170 (68.9-308.3)	180.6 (69.0-335.3)	159.0 (71.2-230.2)	0.45
Hemoglobin	11.1 (9.0-13.7)	11.1 (8.7-12.7)	11.9 (9.3-14.5)	0.22
Platelets****	204 (129.0-283.0)	206.0 (129.0-284.0)	181.5 (103.7-263.5)	0.58
Leucocytes	10.6 (6.9-13.6)	8.9 (6.1-13.1)	12.9 (10.3-16.0)	<0.01
Creatinin, mg/dL, median, (IQR)	11.2 (5.3-1.2)	13.1 (10.8-18.2)	4.9 (3.1-6.5)	<0.01
BUN	75.0 (51.0-109.7)	75.0 (52.5-85.0)	88.0 (46.0-106.8)	0.35
Glucose	149.0 (87.1-218.0)	126.5 (91.2-217.7)	169.7 (85.7-235.1)	0.63
Cholesterol	141.4 (103.6-168.1)	114.3 (94.5-140.8)	141.4 (120.6-168.2)	0.09
Triglycerides	237.4 (145.4-486)	147.8 (107.5-218.3)	237.4 (145.4-486.0)	0.01
Sodium bicarbonate	16.6 (14.3-18.2)	ND	16.6 (14.3-18.2)	NA
Sodium	134.7 (130.9-139.8)	134.5 (131.5-139.7)	135.9 (127.5-140.1)	0.78
Potassium	5.1 (4.1-5.9)	4.5 (4.0-5.5)	5.7 (5.0-6.3)	0.04
Chloride	94.3 (92.0-100.2)	94.2 (91.7-97.1)	99.4 (91.7-103.2)	0.06
Albumin	3.12 (2.73-3.38)	3.1 (2.7-3.4)	3.2 (2.7-3.4)	0.80
Global UF	4450.0 (2387.0-11000.0)	7100 (2800-11800)	2700 (1262-5455)	0.02
Daily UF	825.0 (596.7-1193.8)	900 (633-1383)	815 (434-952)	0.20
Hospital stay, days, n, (%)	6.0 (3.0-11.0)	7.0 (3.5-13.0)	4.0 (2.7-7.5)	0.12
Mortality, n, (%)	29 (61.7)	16 (55.2)	13 (72.2)	0.35
COVID PCR, n, (%)	32 (68.1)	19 (65.5)	13 (72.2)	0.75
Obesity, n, (%)	12 (25.5)	5 (17.2)	7 (39.0)	0.16
DM2, n, (%)	29 (61.7)	20 (69)	9 (50)	0.22
Hypertension , n, (%)	30 (80.9)	28 (96.6)	10 (55.6)	<0.01
COPD, n, (%)	4 (8.5)	3 (10.3)	1 (5.6)	1.0
CVD, n, (%)	9 (19.1)	7 (24.1)	2 (11.1)	0.44
CORADS a 1 2 3 4 5	45/47 (95.7) 0 (0.0) 0 (0.0) 8.0 (17.0) 8.0 (17.0) 29.0 (61.7)	27/29 (93.1) 0 (0.0) 0 (0.0) 5/27 (18.5) 7/27 (25.9) 15/27 (55.6)	18/18 (100) 0 (0.0) 0 (0.0) 3/18 (16.7) 1/18 (5.6) 14/18 (77.8)	0.18
Mechanic Ventilation, n, (%)	27.0 (57.4)	12 (41.4)	15 (83.3)	<0.01
Norepinephrine, n, (%)	28.0 (59.6)	15 (51.7)	13 (73.2)	0.22
Vasopressin, n, (%)	18.0 (38.3)	10 (34.5)	8 (44.4)	0.54
Requirement of HD, n, (%)	2 (4.3)	0 (0.0)	2 (11.1)	0.142
Definitive change to HD, n, (%)	2 (4.3)	0 (0.0)	2 (11.1)	0.142

CKD, Chronic Kidney Disease; SOFA, Sequential Organ Failure Assessment Score; PCR, Polymerase Chain Reaction; BUN, Blood Urea Nitrogen; DM2, Type 2 Diabetes Mellitus; COPD,Chronic Obstructive Pulmonary Disease; CVD, Cardiovascular disease
a CO-RADS Score: 0 Scan technically insufficient for assigning a score, 1 Normal or noninfectious, 2 Typical for other infection but not COVID-19, 3 Features compatible with COVID-19 but also other diseases, 4 Suspicious for COVID-19, 5 Typical for COVID-19, 6 RT-PCR positive for SARS-CoV-2

Results: A total of 47 patients were studied (29 chronic PD patients and 18 incident patients in PD by AKI); the median age was 59 (48-68) years; 63.8% were men; the diagnosis of SARS-CoV2 was confirmed by PCR-RT in 69.1%. Only 2 patients required modality change to HD; the ultrafiltrate per day was 815 (596.1-1193.2) ml. 57.4% of patients required mechanical ventilation. Total mortality was 61.7%; 55.2% in chronic PD patients and 72.2% in incident patients in PD by AKI. A higher SOFA score, need for mechanical ventilation at admission, and the requirement for vasopressors were predictors for mortality ($p < 0.01$).

Table2. Comparison between survivors and non-survivors

Variable†	Total n= 47	No survivors n= 29	Survivors n= 18	Valor p
Years, age, median, , (IQR)	59 (48-68)	59.0 (54.5-68.5)	58.5 (42.2-66.2)	0.24
Male, n, (%)	30 (63.8)	21 (72.4)	9 (50.0)	0.21
CKD diagnosis, years, median, (IQR)	2 (0-5)	2.0 (0.0-5.5)	3.0 (0.7-5.0)	0.59
Hospital stay, days, median, (IQR)	9 (5-15)	7.0 (5.0-14.5)	10.5 (6.0-18.7)	0.28
SOFA, points, median (IQR)	7 (6-10)	8.0 (7.0-12.0)	6.0 (6.0-7.0)	<0.01
APACHE, points, median (IQR)	18 (14-22)	18.0 (15.0-22.0)	15.0 (12.0-22.7)	0.14
D Dimer	672 (468-970)	713.0 (469.5-2450.0)	545.0 (400.0-814.0)	0.18
Lymphocytes	0.62 (0.45-0.93)	0.64 (0.46-0.90)	0.55 (0.33-1.0)	0.67
Platelets	210 (142-285)	210.0 (135.5-271.5)	215.0 (141.2-294.5)	0.77
Procalcitonin	1.37 (0.47-4.55)	1.37 (0.61-4.34)	1.51 (0.41-5.42)	0.84
Ferritin	1244 (531.1-2851.1)	1348.7 (521.4-2699.2)	1185.0 (569.3-3847)	0.68
PCR	170 (68.9-308.3)	189.6 (93.2-300.7)	107 (49.1-370.5)	0.35
Hemoglobin	11.1 (9.0-13.7)	12.3 (9.5-14.2)	10.6 (7.5-12.2)	0.07
Platelets****	204 (129.0-283.0)	187.0 (115.5-253.5)	208.0 (142.5-294.5)	0.45
Leucocytes	10.6 (6.9-13.6)	13.0 (7.9-14.7)	8.5 (6.2-12.0)	0.01
Creatinin, mg/dL, median, (IQR)	11.2 (5.3-1.2)	6.8 (4.9-14.9)	12.5 (7.4-16.7)	0.20
BUN	75.0 (51.0-109.7)	79.8 (53.5-100.0)	72.0 (50.0-85.5)	0.34
Glucose	149.0 (87.1-218.0)	126.5 (85.5-206.1)	170.3 (100.0-230.5)	0.20
Cholesterol	141.4 (103.6-168.1)	120.5 (101.3-1145.8)	117.7 (97.5-152.5)	0.66
Triglycerides	237.4 (145.4-486)	200.7 (135.0-285.5)	166.7 (98.7-242.0)	0.29
Sodium bicarbonate	16.6 (14.3-18.2)	14.3 (13.6-16.4)	22.1 (14.7-24.2)	0.13
Sodium	134.7 (130.9-139.8)	134.6 (128.7-141.3)	134.7 (131.5-138.5)	0.95
Potassium	5.1 (4.1-5.9)	5.1 (4.2-6.0)	5.0 (4.0-5.8)	0.67
Chloride	94.3 (92.0-100.2)	94.3 (92.4-100.8)	93.4 (89.2-98.8)	0.24
Albumin	3.12 (2.73-3.38)	3.1 (2.7-3.4)	3.1 (2.7-3.4)	0.79
Global UF	4450.0 (2387.0-11000.0)	2800 (1750-7600)	9678.5 (4362.5-13900)	<0.01
Daily UF	825.0 (596.7-1193.8)	900 (633-1383)	815 (434-952)	0.20
Hospital stay, days, n, (%)	6.0 (3.0-11.0)	4.0 (2.5-10.5)	8.0 (5.7-14.2)	0.04
CKD, n, (%)	29 (61.7)	16 (55.2)	13 (44.8)	0.35
AKI, n, (%)	18 (38.3)	13 (44.8)	5 (27.8)	
COVID PRC, n, (%)	32 (68.1)	22/32 (68.7)	10/32 (31.3)	0.75
Obesity, n, (%)	12 (25.5)	8/12 (66.6)	4/12 (33.3)	0.74
DM2, n, (%)	29 (61.7)	17/29 (58.6)	12/29 (41.1)	0.76
Hypertension, n, (%)	30 (80.9)	25/30 (65.8)	13/30 (34.2)	0.27
COPD, n, (%)	4 (8.5)	1/4 (25)	3/4 (75)	0.15
CVD, n, (%)	9 (19.1)	6/9(66.7)	3/9 (33.3)	1.0
CORADS a 1 2 3 4 5	45/47 (95.7) 0 (0.0) 0 (0.0) 8.0 (17.0) 8.0 (17.0) 29.0 (61.7)	29/29 (100) 0 (0.0) 0 (0.0) 3/29 (10.3) 4/29 (13.8) 22/29 (75.9)	16/18 (88.8) 0 (0.0) 0 (0.0) 5/18 (31.3) 4/18 (25.0) 7/18 (43.8)	0.10
Mechanic Ventilation, n, (%)	27.0 (57.4)	23/27 (85.2)	4/27 (14.8)	<0.01
Tracheostomy, n, (%)	5/27 (18.5)	4/5 (80)	1/5 (20)	0.63
Norepinephrine, n, (%)	28.0 (59.6)	25/28 (89.3)	3/28 (10.7)	<0.01
Vasopressin, n, (%)	18.0 (38.3)	16/18 (88.9)	2/18 (11.1)	<0.01
Requirement of HD, n, (%)	2 (4.3)	2/2 (100)	0 (0.0)	0.57
Definitive change to HD, n, (%)	2 (4.3)	2/2 (100)	0 (0.0)	0.57

CKD, Chronic Kidney Disease; SOFA, Sequential Organ Failure Assessment Score; PCR, Polymerase Chain Reaction; BUN, Blood Urea Nitrogen; DM2, Type 2 Diabetes Mellitus; COPD,Chronic Obstructive Pulmonary Disease; CVD, Cardiovascular disease
a CO-RADS Score: 0 Scan technically insufficient for assigning a score, 1 Normal or noninfectious, 2 Typical for other infection but not COVID-19, 3 Features compatible with COVID-19 but also other diseases, 4 Suspicious for COVID-19, 5 Typical for COVID-19, 6 RT-PCR positive for SARS-CoV-2

Conclusions: In region of low and lower-middle income countries, PD is an alternative to consider during the COVID-19 pandemic. Ultrafiltration and solute removal goals can be achieved with PD. We observed a higher mortality in incident patients in PD by AKI. The main risk factors for mortality were a high score of the SOFA at admission, need for invasive mechanical ventilation and requirement for vasopressors.

No conflict of interest

POS-879

PREVALENCE OF SARS-COV-2 INFECTION IN RENAL TRANSPLANT RECIPIENTS- A RETROSPECTIVE STUDY

VORA, A*[1], Medanki, R[1], Raman, A[1]

[1]Sunshine Hospital, Nephrology, Hyderabad, India

Introduction: SARS-CoV-2 illness has become a global health crisis. Renal transplant recipients are at a high risk of contracting the infection due to chronic immunosuppression and co-existing conditions. In this study we describe the clinical characteristics, immunosuppression modification and outcomes of SARS-CoV-2 illness in Renal Transplant Recipients.

Methods: All Renal Transplant Recipients admitted with SARS-CoV-2 illness over a period of 13 months from 1STMay 2020 to 31stMay 2021 were included in this study. SARS-CoV-2 illness was documented with HRCT chest and RT-PCR test. The demography, basic disease, clinical manifestation, laboratory data, treatment modalities, immunosuppression modification and outcomes were retrospectively analyzed.

Results: 14 Renal Transplant Recipients were admitted with SARS-CoV-2 illness of which 10(71.4%) were males and 4(28.6%) were females in the age group of 20-60 years with a mean age of 42.64 years.

The basic disease causing ESRD was Diabetic Nephropathy in 3 patients(21.43%), IgA Nephropathy in 4 patients(28.57%), Chronic Interstitial Nephritis in 1 patient(7.14%), Focal Segmental Glomerulosclerosis in 1 patient(7.14%) and Chronic Glomerulonephritis in 5 patients(35.72%).

Of 14 patients, 9(64.29%) had undergone live related renal transplant and 5(35.71%) deceased donor renal transplant.

Co-morbidities included diabetes mellitus in 5(35.7%) patients, hypertension in 6(42.8%) patients, hypothyroidism in 3(21.4%) patients, obesity in 3 patients(21.4%) and allograft dysfunction in 6 patients(42.8%).

The most common presenting symptoms were fever(71.42%), cough(57.14%), dyspnea(50%), loose motions(7.14%) and loss of smell(7.14%).

HRCT Chest revealed a CORADS score of 5(14.3%), 4(21.4%), 3(28.6%) and 2(35.7%). 4(28.6%) patients were admitted in ICU and 10(71.4%) in wards. 3 patients(21.4%) required face mask, 1 patient(7.1%) required mechanical ventilation, 2 patients(14.4%) required NIV, 1 patient(7.1%) required HFO and 7 patients(50%) did not require any mode of ventilation.

12(85.7%) out of 14 patients developed Acute Kidney Injury. 6 patients(50%) developed Acute Kidney Injury Stage 1, 3 patients(25%) developed Acute Kidney Injury Stage 2 and 3 patients(25%) developed Acute Kidney Injury Stage 3. 3 out of 14 patients required haemodialysis.

All patients received steroids. Remdesevir was used in 6 patients(42.9%) for a mean period of 3 days. Calcineurin inhibitor was continued in all patients. Mycophenolate mofetil was discontinued in 12 patients and reduced to 50% of the dose in 2 patients.

Mortality was seen in 3 patients(21.4%). The average duration of hospital stay was 10 days. The most common cause of death was septic shock.

Of 11 patients who survived 6 patients(54.5%) did not have any complications. Other 5 patients developed complications over a mean period of 45 days of which 1 patient developed cytomegalovirus infection, 1 developed cytomegalovirus and tinea infection, 1 developed Chronic allograft nephropathy followed by disseminated mucormycosis, 1 developed rhino-orbital cerebral mucormycosis and 1 developed acute antibody mediated rejection.

Conclusions: The prevalence of SARS-CoV-2 infection in our renal transplant recipients was less as compared to the general population. Fever, dyspnea and cough were the most common presenting symptoms. Mortality was higher among patients requiring intensive care and mechanical ventilation.

No conflict of interest

POS-880

ACUTE KIDNEY INJURY IN PATIENTS WITH COVID-19 USING AN EXTENDED KDIGO DEFINITION: RESULTS FROM THE ISARIC PROSPECTIVE, MULTINATIONAL, MULTICENTRE, OBSERVATIONAL STUDY

Wainstein, M*[1], MacDonald, S[2], Fryer, D[2], Young, K[2], Rossingnol, P[3], Claure del Granado, R[4], Shrapnel, S[5]

[1]University of Queensland, Faculty of Medicine, Brisbane, Australia; [2]University of Queensland, School of Mathematics and Physics, Brisbane, Australia; [3]Universite de Lorraine- INSERM, Centre d'Investigations Cliniques-Plurithématique 14-33- CHRU Nancy- F-CRIN INI-CRCT Cardiovascular and Renal Clinical Trialists, Nancy, France; [4]Hospital Obrero No 2 - CNS, Division of Nephrology, Cochabamba, Bolivia, [5]University of Queensland,

ARC Centre of Excellence for Engineered Quantum Systems- School of Mathematics and Physics, St Lucia, Australia

Introduction: Acute kidney injury (AKI) has been identified as one of most common and significant problems in hospitalised patients with COVID-19 leading to increased morbidity and mortality. Little is yet known about the incidence and impact of AKI occurring in the community or early in the hospital admission in this population. An extended KDIGO (eKDIGO) definition of AKI that incorporates a decrease in the serum creatinine (sCr) has been used in previous studies to improve detection of these cases, particularly in low-income country settings. We hypothesized that such a definition would identify more cases of AKI among hospitalized patients with COVID-19 that may have developed in the community and is resolving in the early part of the admission.

Methods: This was a multinational, multicentre, prospective cohort study embedded in the ISARIC WHO COVID-19 platform. Patients with confirmed rtPCR for SARS-CoV-2 that required hospital admission were registered prospectively. Incidence and staging of AKI was calculated using KDIGO and eKDIGO definitions (Table 1). Time to peak AKI from hospital admission was compared between AKI groups (KDIGO & eKDIGO) by visual inspection using histograms. Descriptive statistics were used to describe the clinical characteristics and compare clinical outcomes among patients with eKDIGO AKI and those without AKI, as well as those with KDIGO AKI and those diagnosed with AKI only from a decrease in sCr (deKDIGO).

Table 1

	KDIGO[9]	eKDIGO
Diagnosis	Increase in sCr by ≥ 26.5 µmol/L within 48 hrs; or Increase in sCr to ≥ 1.5 times baseline, which is known or presumed to have occurred within the prior 7 days.	Increase in sCr by ≥ 26.5 µmol/L OR decrease in sCr by ≥26.5 µmol/L within 48 hrs; or Increase in sCr to ≥ 1.5 times baseline OR a decrease in sCr to ≥ 1.5 times baseline, which is known or presumed to have occurred within the prior 7 days.*
Staging**		
Stage 1	sCr increase to 1.5 – 1.9 times baseline; or Increase in sCr by ≥ 26.5 µmol/L	sCr increase to 1.5 – 1.9 times baseline or an increase in sCr by ≥ 26.5 µmol/L; or sCr decrease to 1.5 – 1.9 times baseline or a decrease by ≤ 26.5 µmol/L
Stage 2	sCr increase to 2.0 to 2.9 times baseline	sCr increase to 2.0 to 2.9 times baseline; or sCr decrease 2.0 to 2.9 times baseline
Stage 3	sCr increase to 3.0 times baseline; or sCr increase by ≥ 353.6 µmol/L or Initiation of renal replacement therapy	sCr increase to 3.0 times baseline or sCr increase by ≥ 353.6 µmol/L or Initiation of renal replacement therapy; or sCr decrease to 3.0 times baseline or sCr decrease to ≤ 353.6 µmol/L

*deKDIGO refers to the group of patients diagnosed with AKI by eKDIGO ONLY by the decrease in sCr.
** Time frames for sCr increases in each stage mirror the pattern for diagnosis: Baseline increases must occur within the previous 7 days and absolute sCr increases (by 26.5 and 353.6 µmol/l) must occur within 48 hrs.
eKDIGO = extended KDIGO definition, sCr = serum creatinine

Results: A total of 75,670 patients from 60 countries and 6 continents were included in this analysis. There were 12,7440 (16.8%) patients diagnosed with AKI using the KDIGO definition and 23,982 (31.7%) using eKDIGO. Stage 3 was more common among the KDIGO group (47%) while Stage 1 was more common in the eKDIGO group (58%). The majority of additional cases detected with eKDIGO were diagnosed (peak AKI) on day 3. Compared to patients without AKI, eKDIGO AKI patients were more likely to be from a low middle-income country (9 vs 4%), have worse renal function on admission (eGFR 54 vs 80 ml/min), more in-hospital complications, higher rate of ICU admission (54 vs 23%), invasive ventilation (45 vs 15%) and increased mortality (38 vs 19%) (all p-values < 0.001). While patients with AKI diagnosed by KDIGO had worse outcomes than the deKDIGO AKI group, the latter still appeared to do worse on these short-term outcomes.

Conclusions: This is the first study to systematically examine an extended KDIGO definition for the identification of AKI against the traditional KDIGO criteria in hospitalized COVID-19 patients. Our population is the largest and only multinational cohort of patients with COVID-19, with a considerable proportion of patients from low- and middle-income countries. The use of an extended KDIGO definition to diagnose AKI in this population resulted in a significantly higher rate of identification compared to traditional KDIGO criteria. These additional cases may represent community acquired AKI that, while mild, appear to have a negative impact on patient's short-term outcomes, highlighting the importance of their timely recognition both for acute management and subsequent follow-up.

Conflict of interest

Potential conflict of interest:

I received a Research Training Scholarship from the University of Queensland to fund the duration of my PhD.

POS-881

EXTRACORPOREAL BLOOD PURIFICATION TREATMENT IN COVID-19 PATIENTS WITH ACUTE KIDNEY INJURY

WAN ZUKIMAN, WZHH*[1], Mokhtar, SA[2], Muhamad, MA[1], Rofii, NBR[1], Arumugam, PA[3], Tay, LL[3], Bidin, MZ[1], Md Shah, A[1], Nor Fadhlina, Z[1], Christopher, LTS[1], Goh, BL[3]

[1]Universiti Putra Malaysia, Medicine, Serdang, Malaysia; [2]Universiti Putra Malaysia, Public Health, Serdang, Malaysia, [3]Hospital Serdang, Nephrology, Serdang, Malaysia

Introduction: Severe COVID-19 infection is associated with high mortality and morbidity, linked to releasing the cytokines that cause hyper-inflammatory state and septic shock. Ventilatory support has always been the mainstay of treatment, but organ support, especially continuous renal replacement therapy, is vital in reducing the death of the patients. Thus, extracorporeal blood purification (EBP) has been proposed to decrease this state in COVID-19 patients with acute kidney injury (AKI).

Methods: A prospective observational study was conducted with an intention-to-treat involving COVID-19 patients with AKI from March to August 2021. We assessed the outcome of patients treated with EBP according to the local practice. The Oxiris ® hemofilter was prescribed in all EBP prescriptions. Main endpoints included reduction of inotropic support, multi-organ function scores, and mortality.

Results: A total of 657 patients were admitted, and 8% (n=57) had AKI. Forty-two (73.3%) are male, 81.7% are obese, 61.4% are smokers, and 52.6% and 43.6% are admitted with categories 4 and 5, respectively. Comorbidities were present in 64.9% of this cohort. The most common AKI cause was dehydration (58%) and pre-admission (68.4%). Twenty-seven (47.4%) patients were admitted to ICU, and 96% (n=26) required renal support.

Continuous renal replacement therapies (CRRT) include EBP and CVVHDF, which were given to 21 patients, while 5 patients had intermittent haemodialysis, including SLEDD. Choice of dialysis modality was important, as CRRT had longer median patients survival (15 +0.7 days) compared to intermittent haemodialysis (10 ±1.6 days) (p= 0.04). The EBP was used in 67.7% (n=14) patients requiring CRRT. EBP usage was associated with a significant reduction in C-reactive Protein (CRP) (p=0.041), inotropic support (p=0.009), and the SOFA Scores (p=0.036). Usage of EBP in CRRT showed a promising survival curve compare to CVVHDF (p=0.020) (Figure1). Nevertheless, 84% of patients requiring dialysis have poor survival outcomes, mostly due to non-dialysis complications, such as secondary bacterial infection.

Conclusions: AKI in COVID-19 patients requiring renal support has poor morbidity and mortality. However, the use of EBP with OXIRIS® hemofilter was associated with reduction in CRP, inotropic support, and SOFA scores of the patients. With these findings, EBP may offer an attractive and alternative treatment mode in the management of hyper inflammation in COVID-19 patients. However, a larger randomize control trial study is needed to validate the practice of EBP in COVID-19 infection with AKI.

No conflict of interest

POS-882

INCIDENCE OF PROTEINURIA AND MICROSCOPIC HEMATURIA IN HOSPITALIZED COVID-19 INFECTED PATIENTS- A SINGLE CENTER EXPERIENCE

Wong, CM*[1], Ching, CH[1], Yeo, GP[1], Asmee, MF[1], Tham, ZD[1], Chen, KK[1], Ho, YB[2], Low, LL[3], Ku Md Razi, KR[2]

[1]Hospital Sultanah Bahiyah, Nephrology, Alor Setar, Malaysia; [2]Hospital Sultanah Bahiyah, Medical, Alor Setar, Malaysia, [3]Hospital Sultanah Bahiyah, Infectious Disease, Alor Setar, Malaysia

Introduction: The Outbreak of COVID-19 has rapidly evolved to global pandemic since December 2019. More than 220 millions people