(74.1 ± 68.4 mg/L vs 160.7 ± 74.4 mg/L, p <0.0001), D-dimer (967.3 ± 949.0 μg/L vs 2810.1 ± 1807.7 μg/L, p <0.0001) and the frequency of procalcitonin increase (29.5 vs 86.4%, p <0.001). The independent factors of adverse outcome (Cox model) were high levels of comorbidity index (p <0.006) and procalcitonin (p <0.006), as well as the IMV use (p <0.0001). It was not possible to establish differences in Groups 1 and 2 depending on the use of individual drugs (Corticosteroids, Baricitinib, Monoclonal Ab IL-6/IL-17/IL-1β, antiCOVID plasma) as well as their combinations.
CONCLUSION: The frequency of SARS-CoV-2 infection in RTR was more than 2 times lower in summer compared to spring and autumn, which suggests a seasonal nature of this infection. The course of the disease was characterized by high hospital and general mortality. High values of the comorbidity index, procalcitonin and the IMV use were independent predictors of the fatal outcome.

MO934 COVID-19 IN RENAL TRANSPLANT RECIPIENTS (RTR)

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BACKGROUND AND AIMS: SARS-CoV-2 infection has a severe course in immunocompromised (RTR) patients. The aim is to study the clinical course and risk factors for adverse outcomes and results of COVID-19 treatment in RTR.
METHOD: At the beginning of the study there were 2580 RTR observed at Moscow Nephrology Center, by the end of it there were 2776 RTR. A retrospective uncontrolled observational study included 279 RTR (M: 172/F: 107, aged 49.9±10.9 yrs.), infected with SARS-CoV-2 from April 1 to November 30, 2020. The period after kidney transplantation before the onset of the disease was 54,0 months (14.0;108.0). After confirmation of COVID-19 by PCR and chest CT MMF/Aza were canceled, CNI dose was minimized (target blood level was CyA 30-50 ng/ml, Tac 1,5-3 ng/ml), a CS dose was increased to 10-15 ng/day. Observation endpoints: discharge/recovery or death.
RESULTS: The number of RTR infected with SARS-CoV-2 from April 1 to May 31, 2020 was 108; there were 42 RTR from June 1 to August 31, 2020; and 129 RTR - from September 1 to November 30, 2020. 59 RTR (21,1%) had a mild course of COVID-19. Patients with moderate and severe course (220/78.9%) were treated in the hospital. The period from the onset of the disease to the hospitalization was 7.1 ± 5.1 days. Severe lung damage (> 50%) occurred in 97 of 220 (44.1%); decrease in SpO2 <95% was seen in 128 of 220 (58.2%); 31 patients died. Thus, hospital mortality was 14.1%, overall mortality was 11.1%. Scr during the course increased from 160.9 ± 68.2 μmol/l to 185.4 ± 130.9 μmol/l (p <0.01) with no signs of acute rejection; and after the recovery, it decreased to 158.1 ± 63.2 μmol/l (p <0.01). Risk factors associated with fatal outcome were analyzed among the survivors (group 1; n-189) and the deceased (group 2; n-31). Groups 1 and 2 differed in the frequency of severe lung damage (69/36.9% vs 24/77.4%, p <0.001); the Charlson comorbidity index (4.4 ± 1.7 vs 6.1 ± 2.5, p <0.001); the frequency of IMV use (0 vs 23, p <0.0001), Scr upon admission (160.3 ± 67.1 μmol/l vs 208.9 ± 99.4 μmol/l, p <0.03), Hb levels (116.3 ± 21.8 g/l vs 91.7 ± 23.9 g/l, p <0.001), white blood cell count (11.1 ± 4.8 × 109/L vs 18.1 ± 7.5 × 109/L, p <0.001), lymphocyte count (0.7 ± 0.4 × 109/l vs 0.4 ± 0.4 × 109/L, p <0.02), albumin (32.4 ± 4.1 g/l vs 25.8 ± 2.8 g/l, p <0.001), glucose (6.1 ± 1.9 mmol/l vs 7.8 ± 2.8 mmol/l, p <0.001), LDG (305.6 ± 135.6 U/l vs 800.8 ± 313.8 U/l, p <0.0001), CRP