Of the patients admitted with a functioning renal graft 1/3 (33.3%) patients did not survive admission.

Of those with an AKI 111/200 (55.5%) had recovery (<1.25x baseline creatinine on discharge or death) whilst 89.5/200 (44.5%) did not. Of those with an AKI who died, 45/106 (59.4%) had recovery prior to death. The mean age for those recovering from AKI was 75.0 (+15.2) years compared to 78.2 (+15.2) years for those who did not recover.

In total 35 patients were admitted to intensive care. The mortality rates for these patients was 18/35 (51.4%). Of these patients 22 had an AKI with a mortality rate of 16/22 (72.7%). The mortality rate for patients with an AKI-1 requiring ITU admission was of 2/5 (40%). 5/6 (83.3%) of AKI 2 and ITU admission and 9/11 (81.8%) for AKI3 with ITU admission. 9 patients admitted to intensive care required acute hemofiltration, mortality rate was 7/9 (77.8%). A further 37 patients required Continuous Positive airway pressure, the mortality rate for these patients was 16/37 (43.2%).

Mortality rate and frequency of developing AKI varied by age with 0/50 (0%) mortality rate for those between 18-50 years old increasing to 2/3 (66.7%) in those over 100. See bar chart for full data set.

The overall mortality for inpatients admitted with COVID-19 was 164/481 (34.1%). In our patient set 277 (57.7%) were male and 204 (42.3%) were female. The mortality rate for females was 63/203 (31.0%) and for males was 101/278 (36.3%).

Conclusions: Patients with COVID-19 who developed an AKI had poorer outcomes than those who did not develop an AKI, especially if they required intensive care. Patient with advanced age also had a poor prognosis.

No conflict of interest

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AN UNUSUAL CAUSE OF RENAL ARTERY THROMBOSIS LEADING TO ACUTE RENAL INFARCTION
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Introduction: Renal artery thrombosis is a rare and often misdiagnosed condition that can lead to acute kidney injury and/or infarct.[1] Nerophologists and other physicians must consider this condition in cases of unexplained abdominal pain and acute kidney injury. We believe the distribution of mural thrombus in the following case led to a novel presentation of acute renal infarction.

Methods: A 59-year-old female presented to an outside hospital with twelve hours of sharp left upper and lower quadrant abdominal pain. (p<0.0001). The median concentrations of urinary α2-microglobulin (n=66) were 50 [25; 81] and 8 [0; 19] mg/g, respectively (p<0.0001). Estimating glomerular filtration rate was lower during the hospitalization compared to the follow-up: 81 [62; 92] versus 87 [66; 98] mL/min/1.73m2 (p=0.0222). At follow-up, a decreased renal function was observed in 10/72 (14%) of patients, with 50% of them presenting decreased renal function before COVID-19 hospitalization and others developing severe acute kidney injury and/or proteinuria during hospitalization. Renal parameters at the timing of urine analysis during the hospitalization and at the follow-up.

Conclusions: In most hospitalized patients with COVID-19, proteinuria and estimating glomerular filtration rate significantly improved after hospital discharge. Only patients who developed severe acute kidney injury and/or heavy proteinuria will require a specific follow-up by nephrologists.

No conflict of interest