pre-existing symptoms. 233 (28.5%) used telemedicine facility and sought telephonic advice from (private) physicians, while 149 (18.2%) were able to undertake an in-person visit to their regular healthcare provider. Among those with ESKD, seven subjects were undergoing regular in-centre haemodialysis. Four of them reported missing their scheduled sessions. One developed severe breathlessness and died despite receiving dialysis.

Conclusions: This is the first study conducted in India to assess the effect of the ongoing COVID 19 pandemic on risk perceptions and access to health services for persons with CKD. Our findings provide insights into the risk perceptions, and practices prevailing in a high CKD burden setting in rural India. We highlight the urgent need for comprehensive guidelines that address continuum of care for NCDs/CKD during the current and future disruptions to routine healthcare service delivery. Prioritization by governments to ensure uninterrupted essential primary healthcare services would be key to preparing for future pandemics.

Conflict of Interest: STOP CKDu study is funded by the Government of Andhra Pradesh under a grand challenges research programme in partnership with Indian Council of Medical Research.

POS-331
ASSOCIATION OF IMPAIRED KIDNEY FUNCTION WITH MORTALITY IN RURAL UGANDA: RESULTS OF A GENERAL POPULATION COHORT STUDY
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Introduction: The burden of kidney disease in sub-Saharan Africa is currently poorly understood. Very limited monitoring and treatment is available for people affected. The association with other diseases and with mortality is unknown in this setting. We sought to determine the association between kidney function and subsequent all-cause mortality.

Methods: In a general population cohort with detailed measurement of health-related parameters in rural Uganda, we estimated the baseline glomerular filtration rate (eGFR) between 2011-2014 in 5,678 participants. We followed participants up to March 2019 with regular ascertainment of mortality and migration. Using multivariable cox regression, we determined associations between baseline eGFR and mortality.

Results: The median age of the participants at baseline was 36 years (IQR 24-50). 60.7% were female, 14.6% hypertensive, 9.7% HIV-positive and 1.8% diabetic. We registered 140 deaths with a median follow-up of 5.0 years. Adjusting for age and sex, HIV, hypertension, diabetes, BMI, marital status, and alcohol and tobacco use participants with eGFR ≤45 mls/min/1.73m2 had six-fold higher mortality compared to those with eGFR ≥90mls/min/1.73m2 (HR 6.12 (95% CI 2.27-16.43)) with strong evidence of a linear trend for risk of mortality as renal function declined (P<0.001).

Conclusions: In a prospective cohort with high rates of follow-up we found that baseline kidney function was associated with subsequently increased mortality in a graded manner. Improved understanding of the determinants of kidney disease and its progression are needed in order to inform interventions for prevention and treatment.

No conflict of interest

POS-332
QUALITY OF LIFE IN PATIENTS WITH DIABETIC NEPHROPATHY: FINDINGS FROM THE KNOW-CKD (KOREAN COHORT STUDY FOR OUTCOME IN PATIENTS WITH CHRONIC KIDNEY DISEASE) COHORT
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Introduction: Diabetic nephropathy (DN) is a major cause of end-stage renal disease, and can affect quality of life (QoL) because it requires arduous lifelong management. This study analyzed QoL differences at baseline and after 5 years between DN anDiabetic nephropathy (DN) is a major cause of end-stage renal disease, and can affect quality of life (QoL) because it requires arduous lifelong management. This study analyzed QoL differences at baseline and after 5 years between DN and non-DN patients with other chronic kidney disease (CKD).d non-DN patients with other chronic kidney disease (CKD).

Methods: The analysis included subjects (n=1766) from the KNOW-CKD (KoreaN cohort study for Outcome in patients With Chronic Kidney Disease) cohort who completed the Kidney Disease Quality of Life Short Form (KDQOL-SF). The factors that influenced the QoL of participants with DN (n=390) were first analyzed, and differences in QoL between DN and non-DN participants was examined. To maintain homogeneity, most factors that influenced the QoL of participants with DN were controlled by propensity score-matched pair sampling using the greedy matching technique. In total, 239 DN and 239 non-DN subjects were finally selected, and differences in the mean KDQOL-SF scores between the 2 groups were then analyzed.

Results: In the multivariate linear regression model, higher QoL scores were found for taller DN subjects and lower QoL scores were found for those who were unemployed or unmarried, received Medical Aid, had lower economic status, had higher platelet counts and alkaline phosphatase levels, and used clopidogrel or insulin. Patient satisfaction (95.9 vs. 64.5, P=0.022) and general health (35.3 vs. 39.1, P=0.041) were significantly lower in the DN group than in the non-DN group. Scores generally decreased in both groups during the 5-year follow-up, and the scores in the work status, sexual function, and role-physical domains were lower among patients with DN than among non-DN patients, but the differences were not statistically significant.

Conclusions: In conclusion, among the DN subjects, socioeconomic factors were found to be strong risk factors for impaired QoL, as well as high platelet counts, high alkaline phosphatase levels, and clopidogrel and insulin use. The DN subjects showed lower QoL than the non-DN subjects in the domains of patient satisfaction and general health. In conclusion, we confirmed that DN itself affected QoL more strongly than other types of CKD.

No conflict of interest

POS-333
THE INDIAN CHRONIC KIDNEY DISEASE STUDY: DETAILED DESCRIPTION OF BASELINE CHARACTERISTICS
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Introduction: The Indian Chronic Kidney Disease (CKD) study is an ongoing, nationwide, multicentric prospective cohort study recruiting participants with mild to moderate CKD that aims to identify risk factors for CKD development and progression and implement effective therapies. Here, we report the baseline socio demographic, etiology of CKD, risk factors and laboratory parameters in the inception cohort.

Methods: Patients with confirmed CKD between 18-70 years of age and estimated glomerular filtration rate (eGFR) of 15-60ml/min/1.73m2 or eGFR >60ml/min/1.73m2 and proteinuria/albuminuria with stable clinical course for at least 3 months have been recruited. Organ transplant recipients, those with malignancy for last 2 years, non-indian ethnicity, pregnancy in case of females, on immunosuppressive therapy, life expectancy <1 year and with poor functional status are excluded. Socio-demographic, details, history related to kidney diseases, traditional and indigenous risk factors, CVD and other co-morbidities are recorded. Blood and urine samples are being collected at baseline and annually. Primary outcome of the study is time to ESRD/RRT, 50% decline in eGFR and any new cardiovascular event.

Results: Total 4056 CKD subjects has been enrolled. The mean age of the cohort was 50.3 +/-11.8 years with 67.2% males. Median eGFR was
POS-334
CKD PROGRESSION AND REGRESSION BY AGE: A POPULATION-BASED COHORT STUDY
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Introduction: The burden of chronic kidney disease (CKD) is expected to increase worldwide with global population aging, potentially increasing the demand for nephrology services. Understanding whether CKD inevitably progresses or may regress can inform clinical decision-making and health policy. We aimed to study both adverse and favorable kidney outcomes by age in adults with CKD.

Methods: We conducted a population-based cohort study using linked administrative and laboratory data from Alberta, Canada. We included adults with incident mild, moderate or severe CKD, defined by outpatient estimated glomerular filtration rate (eGFR) of 45-59, 30-44, or 15-29 ml/min/1.73 m² for >3 months, between April 1, 2009 and March 31, 2015. We excluded individuals who initiated kidney replacement or met treatment criteria for a more severe stage than the stage they qualified for at cohort entry. The exposure was baseline age. The outcome of interest was time to the earliest of CKD progression or regression (increase or drop in eGFR category for >3 months, accompanied by a ≥25% increase or decrease in eGFR from baseline), kidney failure (the earlier of kidney replacement initiation or eGFR <15 ml/min/1.73 m² for >3 months), death, or censoring (out-migration, 5 years after study entry, or March 31, 2017). We used the non-parametric Aalen-Johansen method to estimate the cumulative incidence functions of these competing events.

Results: We included 81,320 individuals with mild, 35,929 with moderate, and 12,237 with severe CKD (mean age 72.4, 77.1, and 76.6 years, respectively). The yearly incidence of CKD increased with advancing age from 180 per 100,000 population at age <65 to 7,250 at age ≥85 years. Overall, regression of CKD was as common as progression in mild (5-year probabilities 14.3% vs. 14.5%) and moderate CKD (18.9% vs. 16.2%), and as common as kidney failure in severe CKD (19.3% vs. 20.4%). In people with moderate or severe CKD, the risk of progression or kidney failure decreased with advancing age, whereas the probability of regression did not vary substantially: from 21.5 to 18.3 and 15.4% in moderate CKD, and 19.8 to 22.4 and 18.7% in severe CKD for age groups 65-74, 75-84 and ≥85 years, respectively. Regression was more common in those with low-grade albuminuria; in people with normal to moderate albuminuria, regression tended to be less likely with advancing age, and more likely in more severe stages. We observed similar probabilities of regression in analyses that excluded participants at risk for acute kidney injury associated with emergency department visits, hospitalizations, and receipt of potentially nephrotoxic procedures or medications, or focused exclusively on those with CKD which had been stable for at least 1 year.

Conclusions: With advancing age the incidence of CKD increases but CKD regression and death are more likely than CKD progression or kidney failure. Population aging may not necessarily translate into increased CKD burden for patients and health services. No conflict of interest