antibiotics along with oxygen therapy in 12 (50%) and 2 (8.3 %) received Plasma therapy along with oxygen therapy and antibiotics. 7 (29.2%) patients died (4 from acute respiratory distress syndrome secondary to Covid-19 pneumonia, 1 had loss of hemodialysis access after fistula failure,1 had myocardial infarction one month after recovery, 1 had fistula rupture and haemorrhagic shock one month after recovery from Covid-19). 17 (70.33) patients are alive of them 14 have fully recovered with mild generalized weakness, 1 had fistula failure, 1 had severe weakness, 1 developed massive intracranial bleed, massive ascites and severe reduction in mobility since Covid-19.

Conclusions: Haemodialysis patients are at high risk of developing COVID-19 24(7.7%) compared to general population of Bangladesh with total 4500000 cases (0.27%). There are also severe consequences of COVID-19 in this population with a mortality rate of 29.2%(7) as compared to the general population of Bangladesh which is 1.4% (6448).

No conflict of interest

POS-530
ANXIETY AND DEPRESSION IN HEMODIALYSIS PATIENTS DURING COVID-19

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Introduction: The current Coronavirus pandemic (COVID-19) presents a peculiar and unusual reality. It affects people certainly physically but also psychologically. Hemodialysis patients move to their center three times a week even during the confinement period. Indeed, in such context, they may experience reactions and phases of stress, anxiety and depression. Hence, it is important to study the psychological impact on them.

Methods: A sample of hemodialysis patients in our unit completed a self-report survey while being treated. It included questions about current mental health and experiences with COVID-19, referring to the Hospital Anxiety And Depression Scale HADS.

Results: We have twenty hemodialysis beds. We were able to isolate two beds for patients with covid-19. During the second wave, we dialyzed 45 patients tested positive for covid-19 in the circuit reserved. Forty patients participated in the study. They were equally divided by gender, with an average age of 49.45 [25-77]. The analysis revealed that only one patient had definite anxiety symptoms, which is an unemployed married female hemodialysed since two years. Two others had questionable anxiety or depressive symptoms; A married woman and a single smoker man, also unemployed and have been on hemodialysis for less than 5 years. Meanwhile, 10% of the studied patients holding history of psychiatric illness had no psychological symptoms.

To adapt to the psychological impact, 50% tend to reduce the number and duration of their hemodialysis sessions. Otherwise, all patients wear their surgical masks. Temperature measurement was systematic at the entrance as well as the washing of hands.

Conclusions: In the long term, this health crisis is expected to significantly improve our understanding of mental health risk factors in chronic hemodialysis patients facing the COVID-19 pandemic. Therefore, we would be able to implement effective prevention strategies to promote mental well-being. No need to stress if we respect the rules of hygiene and the wearing of masks for both patients and health care professionals.

No conflict of interest

POS-531
LIPID PROFILE AND CARDIOVASCULAR RISK IN CHRONIC HEMODIALYSIS PATIENTS

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Introduction: Dyslipidemia is a major risk factor for the occurrence of atherosclerosis and cardiovascular diseases. Associated with chronic renal failure, the cardiovascular risk becomes very high. Hence the interest of screening lipid disorders in patients with end-stage renal failure at the hemodialysis stage.

Methods: We conducted an observational study of the prevalence of lipid disorders in hemodialysis patients in our unit with assessment of their cardiovascular risk in correlation with the Framingham score.

Results: The survey involved 40 patients with an average age of 48.77 years [25-78]. The sex ratio was 0.81. Initial nephropathy was dominated by vascular nephropathy in 15 hemodialysis patients, followed by glomerular nephropathy in 13 patients, and tubulo-interstitial nephropathy in the remaining 12.

The prevalence of dyslipidemia was 52.5%. Lipid disorders were, in decreasing order of frequency; an isolated hypertriglyceridemia at 52.58%, mixed dyslipidemia associating hypercholesterolemia and hypertriglyceridemia at 47.61%. However, 47.5% did not have lipid disorders.

Cardiovascular risk assessment according to the Framingham score revealed a high risk in 12.5% of patients who were predominantly male smokers with physical inactivity, a moderate risk in 20% and a low risk in the majority with a frequency of 67.5%.

Conclusions: This survey found a high prevalence of dyslipidemia with an important cardiovascular risk. This should lead to develop a better strategy to prevent cardiovascular diseases. Dyslipidemia should be detected and treated in patients with predisposing factors because they are at high cardiovascular risk. The lipid profile should not be interpreted according to laboratory standard but according to target values.

No conflict of interest

POS-532
LIVING ORGAN DONOR WAGE REPLACEMENT POLICY: ONE HEALTH CARE ORGANIZATION’S EXPERIENCE

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Introduction: Research findings list financial barriers to living organ donation as a potentially significant reason why individuals choose not to act as living organ donors. Past Alberta Health Services (AHS) salary replacement and benefit programs only partially addressed salary loss for living organ donors. The purpose of the wage replacement policy was (i) To lower known financial barriers to Living Donor Kidney Transplants (LDKTs) among eligible Alberta Health Services employees, and (ii) To increase the number of LDKTs through full wage replacement for eligible AHS employees during post-donation recovery.

Methods: The Kidney Health Strategic Clinical Network and AHS Human Resources explored the feasibility of a policy intended to shield AHS employees from income loss during post-operative recovery from living organ and surgical bone marrow donation. In March 2018, AHS

Conclusions: In the long term, this health crisis is expected to significantly improve our understanding of mental health risk factors in chronic hemodialysis patients facing the COVID-19 pandemic. Therefore, we would be able to implement effective prevention strategies to promote mental well-being. No need to stress if we respect the rules of hygiene and the wearing of masks for both patients and health care professionals.

No conflict of interest
Executive Leadership Team endorsed a policy working group to develop a wage replacement policy. The AHS Living Organ Donor Wage Replacement Policy became effective January 21, 2019, which provides full wage replacement for eligible AHS employees during post-procedure recovery of 12 weeks (organ donation) or 7 days (surgical bone marrow donation).

Results: Based on the 2018 average AHS annual salary of $90,000 and assuming a 12-week convalescence, estimates predicted wage replacement costs of $20,769 per living organ donated by an employee. Based on the living kidney donation rate in Alberta (2011-2016) and the number of eligible AHS Employees (2018), it was predicted 3 of AHS’ 100,000 employees would serve as living organ donors per year. Predicted annual organizational cost: $62,307.

Between January 19, 2019 and November 1, 2020, the number of employees accessing the policy exceeded the initial predictions of 3 AHS staff (unable to report specific dollar savings vs. number of staff given N<10), even in light of the COVID-19 pandemic where most LDLTs were postponed for several months ending June 2020.

Conclusions: This policy was successfully implemented to limit AHS employees’ loss of income during post-operative recovery from living organ and surgical bone marrow donation, and uptake exceeded initial projections without putting significant financial strain on AHS.

Conflict of Interest: All funding provided as in-kind support through Alberta Health Services

POS-533
ASSOCIATION OF END-STAGE RENAL DISEASE WITH MORTALITY IN COVID-19 POSITIVE PATIENTS: A SYSTEMATIC REVIEW AND META-ANALYSIS
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Introduction: End-stage renal disease (ESRD) patients are a high-risk group in the COVID-19 pandemic due to their associated comorbidities. Several observational studies have highlighted a higher mortality rate in COVID-19 positive patients with ESRD. We conducted a systematic review and meta-analysis on studies comparing the association of ESRD on mortality in COVID-19 positive patients.

Methods: Two authors (AK & RC) independently conducted a systematic literature search from three major electronic databases (PUBMED, Scopus and Google Scholar) on all observational studies on COVID-19 infection and mortality in ESRD patients using PRISMA guidelines. The search criteria used included “COVID-19 + dialysis” and “COVID-19 + ESRD” (figure 1). The meta-analysis was conducted on studies showing an association of ESRD with mortality using Review Manager 5.4 software (Cochrane collaboration).

Figure 1: PRISMA flowchart of study selection for meta-analysis

Results: From a total of 1605 studies published between January 2020 and October 2020, three observational studies investigating the association of ESRD on mortality were identified to be suitable for inclusion in the meta-analysis (1-3). The three studies included has a total of 11,419 patients (ESRD–10,912). The mean age of the total population included was 65 years, with a predominance of males (57%). Meta-analysis showed a strong association of ESRD with mortality in hospitalized COVID-19 positive patients (RR 1.38 [1.20, 1.53], p = 0.002; I2: 84%).

Conclusions: This meta-analysis shows ESRD as a strong risk factor associated with mortality in hospitalized COVID-19 positive patients. Further studies are warranted to conduct a meta-regression analysis and tease out the independent association of ESRD with mortality.


No conflict of interest

POS-534
TRAJECTORIES OF CLINICAL AND LABORATORY CHARACTERISTICS ASSOCIATED WITH COVID-19 IN HEMODIALYSIS PATIENTS BY SURVIVAL
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Introduction: We evaluated the trajectories of clinical and laboratory assessments associated with COVID-19 in hemodialysis (HD) patients who survived or died within 30 days after suspicion. For comparison, we also evaluated consistent trajectories before suspicion in patients tested for SARS-CoV-2 who were found to be COVID-19 negative.

Methods: We used data from adult (age ≥18 years) HD patients treated at a national dialysis network (Fresenius Kidney Care, Waltham, MA) in the United States who received RT-PCR testing to investigate suspicion of a SARS-CoV-2 infection between 01 May and 01 Sep 2020. Suspicion of SARS-CoV-2 infection was determined at presentation by active signs and symptoms of a flu-like illness. We excluded data from patients under investigation for SARS-CoV-2 who did not have a documented RT-PCR result, which included asymptomatic patients who were exposed to someone with known COVID-19 and were monitored for symptoms. Using an exploratory analysis design, we computed mean daily values for an array of variables 90 days before the first date of suspicion. Nonparametric smoothing splines were used to fit data for individual trajectories and estimate the mean change over time since suspicion of SARS-CoV-2 in patients who were confirmed by RT-PCR test to be positive or negative for COVID-19. Among COVID-19 positive patients, we stratified data for those who survived or died within 30 days of suspicion; trajectories were plotted 90 days after suspicion in

Figure 1: Association of COVID-19 mortality and associated characteristics

S232 Kidney International Reports (2021) 6, S1–S362