concerns about the involvement of policy in vaccine development. Vaccines to avoid according to participants were: Astra Zeneca (62%), Synovac (26%), Sputnik (8%), and Pfizer (4%).
Conclusion: The intention to be vaccinated against COVID-19 reached 81% among Tunisian HCW. Acceptance of the vaccine, even among medically informed individuals, is based on a personal perception of the risks and benefits of vaccine safety. Hence the need for campaigns targeting both the general population and the HCW.
Disclosure of Interests: None declared

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AB1086 VACCINE HESITANCY AGAINST COVID-19 VACCINES IN PATIENTS WITH AUTOIMMUNE RHEUMATIC DISEASES AND EFFECT OF SPECIALIST COUNSELLING ON VACCINE HESITANT PATIENTS WILLINGNESS TO TAKE VACCINE

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Background: Vaccination is one of the most significant public health achievements; however, the success has been marred with vaccine hesitancy. The reasons for vaccine hesitancy are neither singular nor straightforward and arise from a complex interplay between scientific, religious and political beliefs. This study aims to understand the possible reasons for vaccine hesitancy in patients with autoimmune rheumatic diseases and the effectiveness of Specialist counselling on vaccine-hesitant patients willingness to take the vaccine.
Objectives: 1. To assess causes of Vaccine hesitancy against COVID-19 vaccines in patients with autoimmune rheumatic diseases.
2. To study the effect of specialist counselling on vaccine-hesitant patients willingness to take vaccine.
Methods: Study design: We conducted an observational survey-based in person cross-sectional study. Patients attending a tertiary care hospital's outpatient department were asked about their vaccination status. Those unvaccinated were asked reasons for vaccine hesitancy The vaccine-hesitant patients were counselled by the treating rheumatologist and asked regarding their willingness to take the vaccine after the counselling. The patient responses were recorded. Sample: Convenience sampling was used, so the sample size was not calculated. Inclusion and exclusion criteria: All adults(>18yrs) with AIRD coming to the rheumatology OPD. Those vaccinated, recently infected(within 6 weeks), and non-AIRD patients were excluded. Data collection: The questionnaire included patients' demographic details, Diagnosis, medication details, and response to the reason for vaccine hesitancy. Statistical analysis: Descriptive statistics were performed by calculating measures of central tendency for quantitative variables and using counts and percentages for qualitative and nominal variables.
Results: A total of 322 patients participated in the study with a mean age of 40 years(18-76), with 73%(234) females and 27%(88) males. Most patients had Rheumatoid Arthritis(40%) followed by SPA (27%), SLE(13%) and others and may were on immunosuppressive medications(95%). A significant proportion of patients(60%) had more than one reason for vaccine hesitancy. Almost 60% of the respondents feared their disease might flare post-vaccination, while almost half(44.4%) were hesitant to take the vaccine due to the fear of vaccine side effects and more than one third (35%) feared vaccine may not be effective on them as they were on immunosuppressive medications. Other major causes of vaccine hesitancy were the inability to get a chance to get vaccinated (18%), doubts about vaccine efficacy (15%), and fear of injections (10%).Most patients(91%) were willing to take the vaccine after specialist counselling and only 28 of the 322 (9%) were unwilling even after specialist counselling.
Conclusion: Vaccine hesitancy can be multifactorial. Major reasons for vaccine hesitancy in patients with autoimmune rheumatic diseases were fear of flare of disease post-vaccination, fear of vaccine side effects and doubts whether the vaccine would work in patients taking immunosuppressive medications. Most patients were willing to take vaccine after counselling by a rheumatologist.
Disclosure of Interests: None declared

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AB1087 COVID-19 IN PATIENTS WITH ANCA ASSOCIATED VASCULITIS

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Background: In patients with ANCA associated vasculitis (AAV) a higher mortality rate due to COVID-19 has been observed compared to general population[1].
Objectives: We aimed to evaluate the frequency and severity of COVID-19 in a well-defined AAV cohort.
Methods: Medical records of AAV cases diagnosed at our secondary/tertiary rheumatology center between January 2010 and February 2020 and followed during the COVID-19 pandemic between March 2020 and November 2021 were analyzed.
Results: During the 122-month period, AAV was newly diagnosed in 117 patients. Fifteen patients died before the beginning of COVID-19 pandemic. Of the remaining 102 patients (68.8% females, 42 (41.2%) GPA; 32 (31.4%) MPA; 19 (18.6%) EGPA and 8 (7.8%) not further clinically subclassified AAV), SARS-CoV-2 infection was documented by PCR test in 11 (10.8%) patients (9 (81.8%) females; mean (SD) patient age at COVID-19 65.3 (±20.4) years; 7 GPA and 4 MPA). Five patients had mild COVID-19 symptomatically treated at home, and 6 patients had severe infection. Clinical features of COVID-19 are presented in Table 1. Three patients (27.3%) died due to COVID-19. There were 5 additional deaths of AAV patients during pandemic period, all these related to cancer progression. At the time of diagnosed COVID-19, AAV was in remission in 10 patients and relapsed 2 months prior in one patient. All patients except one were receiving immunomodulatory treatment (steroids only 2; DMARDs only 4; steroids + DMARDs 4). Of the 97 patients eligible for vaccination against COVID-19 (5 AAV patients died before vaccines against SARS-CoV-2 were available), 79 (81.4%) received by the end of November 2021 at least one dose, including 2 patients that later developed COVID-19 (both fully vaccinated; 2.5% breakthrough rate).

Table 1. Presentation of COVID-19 in AAV patients

Characteristics (11 patients)	No.	Characteristics (11 patients)	No.
COVID duration (days)	18(±9)	Respiratory insufficiency	4
Fever	6	Chest pain	5
Headache	6	Abdominal pain	1
Rhinitis	2	Diarrhoea	1
Smell loss	4	Malaise/fatigue	7
Taste loss	4	Myalgia	4
Cough	6	Arthralgia	4
Dyspnoea	7		

Conclusion: Our study shows that COVID-19 heralds a poor prognosis in AAV, with over 50% patients having severe disease and 25% deaths.
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AB1088 COVID-19 VACCINATION OF SPONDYLOARTHRITIS PATIENTS RECEIVING BIOLOGICAL THERAPY: REAL-LIFE DATA

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Background: Considering the concerns regarding COVID-19 vaccine safety among patients with rheumatic diseases due to a lack of data, an urgent need for studies evaluating safety profiles of vaccines emerged.
Objectives: Vaccination against the coronavirus disease-2019 (COVID-19) started in March 2021 in the group using biological therapy in our country. In this study, post-vaccine real-life data of patients with spondyloarthritis (SpA) followed up with biological therapy were analyzed.
Methods: Adult patients diagnosed with SpA who were followed up under biological therapy and vaccinated by CoronaVac inactive SARS-CoV-2 orBNT162b2 messenger RNA (mRNA) COVID-19 (Pfizer-BioNTech) vaccine were included in our observational, multicenter, prospective study.
Results: A total of 287 patients (58.2% male; mean age: 47) were included in the study. 202 (%70,4) of patients were being followed up with the diagnosis of AS, 40 (%13,9) of them with PsA, 32 (%11,1) of them with nr-axSpA, 11 (%3,8) of them with enteropathic arthritis, and 2 (%0,7) of them with uSpA. The

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most common comorbidities were found to be HT (n:65; 22.6%) and DM (n:38; 13.2%). While 221 (77%) of the patients were receiving biological therapy alone, 27 (9.4%) patients were using methotrexate, 25 (8.7%) patients were using sulfasalazine, and 12 (4.2%) patients were using leflunomide. The median duration of biological therapy was 40 weeks (19-75 IQR). The most commonly used treatment was infliximab (26.8%), adalimumab (23.3%) was the second (Table 1). It was determined that 207 (72.1%) of the patients preferred inactivated virus vaccine, while 80 (27.9%) preferred mRNA vaccine. When the time between the biological treatment and the day of vaccination is examined, detected median time between biological treatment and the first dose of vaccination is 11.5 days (5-19 IQR), between the first dose of vaccination and biological treatment is 14 days (7-21 IQR), between treatment and the second dose of vaccine is 14 days (5-23.5 IQR), and between the second dose of vaccine and the next biological treatment is 12.5 days (7-15 IQR). While 25 (8.7%) of the patients had COVID-19 infection before vaccination, 7 (2.4%) patients were found to have COVID-19 after vaccination (p<0.001). While two of the patients who had COVID-19 infection in the pre-vaccination period required hospitalization, none of the patients who had COVID-19 in the post-vaccination period required hospitalization. The rate of patients who developed side effects after the first dose of the vaccine was 20.6%. The side effects seen, respectively, were detected as pain-redness at the injection site (16%), fatigue (11.8%), headache (8.4%), muscle-joint pain (7.3%) and fever (5.6%). The rate of patients reporting side effects after the second dose of the vaccine was 17.1%. The incidence of side effects after mRNA vaccine was found to be statistically significant compared to inactivated virus vaccine in terms of both doses (p=0.011, p<0.001). Major side effects such as myocarditis, anaphylaxis-angioedema, myocardial infarction, and thrombosis were not observed in any of the patients included in the study. There was no evidence of disease activation in the median follow-up of 209 days (145-280 IQR) after vaccination.

Conclusion: During the follow-up of the patients during the study, no major vaccine-related side effects, post-vaccine disease activation and the need for treatment change were not detected. In order to more accurately evaluate the efficacy of the vaccination program in the patient population using biologic agents, larger-scale studies including unvaccinated individuals are needed.

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AB1089 PSYCHOSOCIAL IMPACTS OF THE COVID-19 PANDEMIC ON ETHIOPIAN AND CANADIAN RHEUMATOLOGY PATIENTS

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Background: The Coronavirus-2019 (COVID-19) pandemic increased psychosocial distress in the general population and in patients with rheumatic disease. Limited data exists on the impact of COVID-19 in rheumatology patients living in Africa.

Objectives: To describe COVID-19 related illness and psychosocial impact in Ethiopian (ET) rheumatology patients attending the only public rheumatology clinic in Ethiopia (Tikur Anbessa Specialized Hospital (TAH) in Addis Ababa). To compare findings in ET with findings in Canadian (CA) rheumatology patients.

Methods: Between May 1 and Oct 31 2021, 130 patients attending the TAH rheumatology clinic answered questions related to COVID-19 infection, symptoms and testing, and psychosocial impacts of the COVID-19 pandemic. We assessed depression (Patient Health Questionnaire- 9), anxiety (General Anxiety Disorder-7; GAD7), COVID-19 stress factors and coping measures, Resilience (Brief Resilience Scale-BRS) and medication compliance (Morisky medication adherence scale – 4 item; MAS4). Rheumatic disease severity was assessed with the Routine Assessment of Patient Index Data-3 (RAPID-3). Questionnaires were translated to Amharic. Descriptive statistics are reported [mean (standard deviation), median (25%, 75%) number and percent.)] and compared to data of 97 CA patients with rheumatoid arthritis (RA) and lupus patients from Quebec[1].

Results: ET patients were mainly female (71%) with a mean (SD) age of 47 (16), and resided in the capital city (Addis Ababa) (72%). Half had RA or lupus. A quarter of patients had moderate to severe rheumatic disease severity desite good medication adherence [MAS4 score of 3(2,4)]. Most (89%) reported no COVID-19 symptoms since the beginning of the pandemic, were not tested for COVID-19 and reported few risk factors for COVID-19 exposure. Eight (6%) ETs were diagnosed with COVID-19; 2 required hospitalization. Diagnosed patients reported a median of 2 COVID-19 symptoms (range 0-8; mainly cough, fever and malaise). Within the entire cohort, depression (PHQ9= 10 or above) and anxiety (GAD7=10 or above) were more frequent in ETs than CAs (depression 30% vs 3%; anxiety 16% vs 1%) yet nearly half (47%) of ETs had normal or high resilience levels. The most common COVID-19 stressors were risk of contracting COVID illness personally [ETs vs CAs risk ratio(95% confidence limits- CL); 0.67 (0.5, 0.99)] or of loved one [0.56 (0.36, 0.86)]. More ETs reported COVID-19 related stress related to difficulty obtaining food, medicine or other essentials [1.74, (1.00-3.0)], and getting needed supports [1.97 (1.03, 3.77)] (Table 1). CAs and ETs used similar levels of problem solving [median (25%,75%) CA 3.3 (2.8, 3.3), ET 3.5 (3.0, 3.7)] and emotion-focus [CA 2.5 (2.2, 3.1); ET 3.3 (2.8, 3.7)] coping strategies.

Table 1. COVID-19 related stressors reported by Ethiopian and Canadian rheumatology patients

Common stressors from the coronavirus pandemic reported as severe †	ET % reported	CA % reported	RR (95% CI) ET vs CA
Getting sick	28	41	0.67 (0.5, 0.99)
Having a loved one who becomes ill	23	41	0.56 (0.36, 0.86)
Difficulty getting food, medicine and other essentials	29	16	1.74 (1.0-3.0)
Difficulty getting support or help	24	12	1.97 (1.03-3.77)
Postponement or cancellation of tests	8	20	0.42 (0.18, 0.95)
Losing a job or experiencing a drop in income	19	10	0.185 (0.90, 3.81)
Having more responsibilities at home	21	20	1.06 (0.59, 1.87)
Having to work in a place likely to expose you to the coronavirus	20	27	0.73 (0.42, 1.24)
Postponement or cancellation of medical visits	19	15	1.2 (0.63, 2.28)
Changes in treatments	7	15	0.43 (0.17, 1.06)

†Severe stress = score 2 (moderately) to 5 (extremely)

Conclusion: During the COVID-19 pandemic, depression was more common in ETs compared to CAs with rheumatic disease. COVID-19-related stressors due to insecurity in obtaining the basic essentials and support were more pronounced in ETs. Differences between ETs and CA in these stressors may reflect local public health and economic supports. There were no differences in coping strategies.

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AB1090 IMPACT OF THE COVID19 PANDEMIC ON THE SOCIAL BEHAVIOR OF PATIENTS WITH RHEUMATIC DISEASES

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Background: Depression in rheumatic diseases negatively influences the support network and the perception of company of these patients (1).

Objectives: To describe how the COVID-19 pandemic affects the social activitiesn patients with chronic rheumatic diseases such as Rheumatoid arthritis (RA), Systemic Lupus Erithematosus (SLE) and Spondyloarthritis (SpA).

Methods: Design: Observational, longitudinal study of a series of patients. Patients: RA (ACR/EULAR 2010 classification), SpA (ASAS/EULAR 2010 criteria), and SLE (ACR 1997 criteria) patients, age ≥ 18 years. Questionaries for the evaluation of participation in social activities is the Patient Reported Outcomes Measurement Information Systems (PROMIS) v2.0 Short-Form (8 items, PROMIS-APS) at baseline (OCT to DEC 2019) and after 18 months of pandemic (SEP to DEC 2021) were performed. Variables evaluated were: social activities in terms of various factors, such as satisfaction with social roles mobility, depression, companiony social isolation, emotional support, instrumental support, support via information and ability to participate in social activities. All the variables were evaluated using the PROMIS questionnaire with quantitative scores. We also recorded demographic, clinical, and comorbidity data. Statistical analysis: Multivariate Linear Regression (Dependent variable: PROMIS ability to participate in social activities 18 months COVID19) was performed.

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