Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.
TABLE 2. Represents lab parameters / mode of RRT / Outcomes of both groups in first and second waves

| variables       | First wave Age<65 years | First wave Age>65 years | p value | Second wave Age<65 years | Second wave Age>65 years | p value |
|-----------------|-------------------------|-------------------------|---------|--------------------------|--------------------------|---------|
| Mean Hb          | 9.0 ± 1.2               | 9.1 ± 1.3               | 0.5     | 8.6 ± 1.6                | 8.2 ± 2.3                | 0.2     |
| Mean Total Leucocyte Count | 8935 ± 4806             | 9037 ± 4685             | 0.06    | 8935 ± 2334              | 12180 ± 3084            | 0.7     |
| Mean Blood Urea  | 96.7 ± 35.0             | 108.8 ± 45.5            | 0.009   | 99.32 ± 28.9             | 101.23 ± 25.6           | 0.09    |
| Mean S. creatinine | 8.7 ± 3.55              | 8.26 ± 3.47             | 0.2     | 7.66 ± 3.4               | 7.64 ± 2.31             | 0.9     |
| NIV support      | 66%                     | 75.2%                   | 0.01    | 90.2%                    | 73.4%                    | 0.03    |
| q SOFA score (2 / 3) | 44%                    | 49%                     | 0.01    | 17%                      | 36%                      | 0.01    |
| RRT - HD         | 85%                     | 36%                     | 0.01    | 52%                      | 42%                      | 0.03    |
| RRT - PD         | 5.16%                   | 22%                     | 0.01    | 43%                      | 54%                      | 0.03    |
| CKD 50           | 78%                     | 74%                     | -       | 74.7 %                   | 75 %                     | -       |
| CKD A/D          | 4.2%                    | 17.2%                   | -       | 10.6%                    | 18.5%                    | -       |
| AKI              | 17.8%                   | 8.6%                    | -       | 14.7%                    | 6.5%                     | -       |
| Mortality        | 38.7%                   | 63.5%                   | 0.001   | 32.9%                    | 40.6%                    | 0.02    |

Conclusions: Percentage of Geriatric COVID 19 patients with Renal dysfunction in first wave and second wave were 21.1% and 15.2% respectively.

Patients of Geriatric COVID19 group had higher prevalence of comorbidities compared to younger group.

Presentation with fever is less common in Geriatric group but breathlessness was the predominant symptom in both waves.

Patients of Geriatric COVID 19 Infection with Renal dysfunction has higher q SOFA scores, requires more NIV support compared to younger COVID 19 groups.

Peritoneal dialysis was predominant mode of dialysis in Geriatric COVID 19 group compared to younger group.

Mortality was higher in Geriatric COVID19 group compared to younger COVID 19 group in both waves.

No conflict of interest

POS-026

REMDESIVIR IN PATIENTS WITH ACUTE OR CHRONIC KIDNEY DISEASE IN COVID-19 AND IMPACT ON LIVER FUNCTION

Thakur, A*, bhata, R, *marwaha, A, tiwari, SC1
1SHRIMANN MULTISPECIALITY HOSPITAL, nephrology, JALANDHAR, Indi,
2Shrmann superspeciality hospital, nephrology, jalandhar, India

Introduction: Acute Kidney Injury is commonly present in COVID-19 hospitalised patients where the chronic kidney disease and end-stage renal disease are also common comorbidities in patients who develop severe COVID-19. These patients requires antiviral medication as early as possible but there is no current guidelines for use of Remdesivir therapy in these patients and drug is not used initially in these patients. Antiviral strategies are desperately needed in this population to treat these patients as early as possible.

Methods: We conducted an observational, retrospective cohort study of adults with COVID-19 confirmed by RT-PCR who had eGFR < 30mL/min/1.73m2 or received RRT prior to receiving at least one dose of Remdesivir. eGFR was estimated from the serum creatinine value just prior to the first dose of Remdesivir using the Chronic Kidney Disease Epidemiology Collaboration calculator. The majority of patients requiring supplemental oxygen were offered Remdesivir for 5 days; eGFR cut-offs were not used as a strict exclusion criteria. All patients with eGFR < 30mL/min/1.73m2 who received at least one dose of Remdesivir in hospital were included in the study. AKI was defined as at least a 1.5-fold rise in creatinine from baseline per KDIGO criteria. CKD was defined as eGFR < 60mL/min/1.73m2 between 7-365 days prior to admission. Patients with “stable CKD” did not meet criteria for AKI at the time of starting Remdesivir. ESRD was defined as requiring RRT > 3 months prior to hospitalization. The primary objectives were to describe changes in ALT, AST, and Bilirubin and serum creatinine during Remdesivir therapy, and to report adverse effects attributed to Remdesivir.

Results: A total of 41 patients with eGFR < 30 mL/min per 1.73 m² at the time of Remdesivir initiation were included in the study. 27 patients were in intensive care, and 14 patients were mechanically ventilated at the time of Remdesivir initiation. At the time of Remdesivir initiation, 30 patients were receiving RRT. 11 patients with eGFR < 30 mL/min per 1.73 m² were not on RRT at the time of starting Remdesivir. Four patients developed ALT more than the upper limit of normal and only two patients developed ALT more than 5 times, that may be contributory to other factor also.

Conclusions: In general, limited information is available on the impact of SARS-CoV-2 infection in patients with eGFR less than 30. Impact of Remdesivir on these patients and their liver functions are not well studied. Although the available clinical data are limited, but it shows that impact of Remdesivir on liver function in patients of eGFR less than 30 is limited. However further studies are needed.

No conflict of interest