

Table. Revascularization outcomes

	Endovascular (N = 11)	Open (N = 24)	None (N = 11)	Overall (N = 46)
Age, mean (SD)	65.1 (6.17)	60.8 (8.59)	62.2 (13.6)	62.2 (9.51)
Diabetes mellitus	4 (36.4)	9 (37.5)	5 (45.5)	18 (39.1)
Rutherford ALI scale				
I	0 (0)	0 (0)	3 (27.3)	3 (6.5)
Ila	4 (36.4)	9 (37.5)	2 (18.2)	15 (32.6)
Iib	5 (45.5)	14 (58.3)	2 (18.2)	21 (45.7)
III	2 (18.2)	1 (4.2)	4 (36.4)	7 (15.2)
No preoperative anticoagulation medication use	6 (54.5)	22 (91.7)	22 (91.7)	37 (80.4)
No preoperative antiplatelet medication use	3 (27.3)	13 (54.2)	7 (63.6)	23 (50.0)
Preoperative aspirin use	18 (39.1)	9 (37.5)	4 (36.4)	18 (39.1)
Successful revascularization with symptom resolution	4 (36.4)	15 (62.5)	0 (0)	19 (41.3)
Major amputation	1 (9.1)	1 (4.2)	1 (9.1)	4 (8.7)
Ventilation in days, mean (SD)	17.7 (9.61)	10.6 (13.0)	8.50 (7.78)	12.3 (10.8)
Average length of stay in ICU, days, mean (SD)	8.60 (9.86)	3.24 (4.96)	3.29 (5.19)	4.66 (6.85)
Average length of stay in hospital, days, mean (SD)	11.9 (10.5)	12.8 (14.3)	11.9 (10.5)	13.2 (13.3)
Death, in hospital	3 (27.3)	3 (6.5)	4 (36.4)	10 (21.7)
Death, within 30 days	1 (9.1)	1 (4.2)	0 (0)	3 (6.5)

ICU, Intensive care unit; SD, standard deviation.
Data are presented as number (%) unless otherwise indicated.

VESS02.**Revascularization Outcomes of Acute Limb Ischemia in Patients With COVID-19**

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Objective: Acute limb ischemia (ALI) is one of the most catastrophic thrombotic manifestations of COVID-19 resulting in limb loss if not promptly treated. Our goal is to evaluate revascularization outcomes of ALI in patients with COVID-19 who underwent either open or endovascular treatment.

Methods: The Vascular Surgery COVID-19 Collaborative started in March 2020 to assess hematological changes of COVID-19. We performed an interim data analysis on 46 patients with COVID-19 associated ALI submitted to the ALI module of the Vascular Surgery COVID-19 Collaborative REDcap database from 10 institutions in the United States.

Results: Among the 46 patients included in the analysis, the mean age was 62.2 (standard deviation [SD]: 9.51) years. The majority of patients were male (73.9%). A total of 67.4% were White, 13% were Hispanic, and 4.3% were Black. In total, 93.5% of patients met Rutherford's criteria of ALI class 2 or 3. On average, patients developed ALI 12.2 (SD: 13.5) days after a positive COVID test. Revascularization was attempted using open thrombectomy in 50.0%, endovascular lysis or thrombectomy in 23.9%, and bypass in 2.2%, and revascularization was not attempted in 23.9% of the patients (Table). Revascularization was successful in 41.3% with symptom resolution and 15.2% with limb salvage but persistent symptoms; 2.2% had minor amputation, 4.3% ultimately had a major

amputation, 4.3% required reoperation, and revascularization was unsuccessful in 10.9% of patients. The average length of hospital stay was 13.2 (SD: 13.3) days, the average intensive care unit (ICU) length of stay was 4.66 (SD: 6.85) days, and the average ventilation days was 12.3 (SD: 10.8) days. Overall, in-hospital mortality was 21.7%, 8.7% had major amputation, 8.7% had stroke, 6.5% required major limb intervention, and 2.2% had sepsis. Successful revascularization rate was 62.5% in the 24 patients who underwent open surgery vs 36.4% in the 11 patients who underwent endovascular repair. The average length of stay in the ICU was shorter in the open group (mean = 3.24 days) than in the endovascular group (mean = 8.60 days). Of the 11 patients who had no revascularization attempt, 36.4% died, 18.2% had a major amputation, 9.1% had a pulmonary embolism, and 9.1% had a stroke.

Conclusions: COVID-19-associated ALI carries a high mortality. Patients with COVID-19 who develop ALI can be managed successfully with open surgery or endovascular intervention. In our cohort, open revascularization resulted in reduced ICU stay and reduced ventilation days with improved limb salvage than the endovascular group. Further data are needed to develop management algorithms for ALI in patients with COVID-19.

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VESS03.**Integration of Palliative Care Consultation Into the Management of Patients With Chronic Limb-Threatening Ischemia: A Pilot Study**

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Objective: We assessed the feasibility of integrating palliative care consultation into management of patients with chronic limb-threatening ischemia (CLTI).

Methods: This was a single institution, prospective, observational study supported by the Society of Vascular Surgery Vascular Quality Initiative that looked at the impact of palliative care consultation for patients with CLTI. A health-related quality-of-life questionnaire comprising Vascul-QoL-6 and a modified palliative care survey was administered before and after palliative consultation to patients admitted to the vascular service for ≥ 48 hours. Length of stay and mortality were compared between our study group and a historically matched cohort of patients with CLTI.

Results: Over a 14-month enrollment period, 44% of patients (N = 39) with CLTI (rest pain = 36%, tissue loss = 64%) admitted to the vascular service received palliative care consultation, compared with 5% of patients who would have met criteria over the preceding 14 months before our protocol was instituted. The mean age was 69, 23% were female, 97% White, and 49% were independently ambulatory (Table). Revascularization included bypass (46%), peripheral vascular intervention (23%), and femoral endarterectomy (21%). A total of 26% underwent minor amputation or wound debridement, 15% underwent major amputation, and no patients received medical management alone. The mean Vascul-QoL-6 on admission was 10.4 (standard deviation: 4.2). After receiving palliative care consultation, patients reported experiencing less emotional distress than before consultation (2.1 vs 2.7, $P = .03$). They also reported being less bothered by uncertainty regarding what to expect from the course of their illness (2.5 vs 3.4, $P = .002$). Fewer patients reported being unsure of the purpose of their medical care after palliative care consultation (8%) vs before (18%) although this was not statistically significant ($P = .10$). Median length of stay was longer in the study group compared with the historic cohort (8 vs 7 days, $P = .02$). There was no difference in 30-day mortality (3% vs 8%, $P = .42$) between the study group and the historic cohort (N = 77).

Conclusions: Integrating inpatient palliative care consultation into the routine management of patients with CLTI is feasible and beneficial.



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