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thromboembolic disease, we hypothesized that the number of ED patients with CVTs increased after the arrival of COVID-19 in the New York City area in early March 2020.

Methods: Retrospective cohort design. EDs of 28 hospitals within 150 miles of New York City. Hospitals were teaching or non-teaching and rural, suburban or urban. Annual ED volumes were from 12,000 to 122,000. The database we had available included consecutive patients seen by ED physicians from March through November in 2019 and 2020. We tallied the number of patients diagnosed with CVTs using International Classification of Disease (version 10) codes.

Results: The database contained a total of 1,975,352 visits, 1,161,080 in 2019 and 814,252 in 2020 (a 30% decrease from 2019 to 2020). In 2019 six patients were diagnosed with CVT and in 2020, three patients. For these CVT patients, the median age [interquartile range] was 44 [36-50] and 78% were female.

Conclusion: Contrary to our hypothesis, we found that after the arrival of COVID-19 in our area, visits for CVTs did not increase. We speculate that total ED visits decreased in 2020 because of public health mandates and fear of contracting COVID-19. The decrease in visits for CVTs that we found may have been due to the overall decrease in ED visits. Another factor may have been that ED testing was reduced to move patients out of the ED expeditiously, to lower the risk of exposing COVID-19. The study of the data shows that visits for CVTs decreased by 30%. This may be due to a decrease in the overall number of visits to the ED, which could be attributed to public health measures to reduce the spread of COVID-19.

94 COVID-19 Prognostic Factors: A Retrospective Study Challenging the Risk Factors Contributing To Poor Outcomes.
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Study Objectives: COVID-19 research has shown that factors associated with severe illness are age, some socioeconomic factors, male sex, smoking, obesity, some chronic medical conditions, immunosuppression, and certain laboratory findings. This study provides data showing various factors associated with poor prognosis in Louisiana and compared with national data, especially with its majority-Black population.

Methods: Data was collected from 1381 patients who tested positive for COVID-19 from March 1st to May 5th, 2020 at various medical facilities in Shreveport, Monroe, and New Orleans. Variables included age, sex, race, ethnicity, body mass index (BMI), and comorbidities. Daily labs included CBC, BMP, CRP, ESR, D-Dimer, LDH, AST, ALT, Bilirubin, Alkaline Phosphatase, Ferritin, Troponin, CPK, PT, PTT, and INR. Outcomes were patient discharge status, intubation, and deterioration during the hospital course.

Results: The mean age was 55.39 years old with the most positive tests from 55-69 years of age. The highest fatality rate was in ages 75-84 and 95-99. Congestive heart failure (CHF) patient had the highest fatality rate, at 42.47%. Racial distribution was similar to the studied areas but, had a higher rate of Black patients (63.1%) and a lower rate of White patients (23.5%). Fatality rates of Black patients were higher (17.26%) than White patients (14.94%). Black patients accounted for 59.54% of the deaths, while White patients accounted for 19.85%. Sex distribution was mainly female (55.8%). Males had a higher fatality rate (22%) than females (12.6%). The mean BMI was 32.3, being the Obese I category, while most patients were in the overweight category. As BMI increased, fatality rates decreased. Creatinine, LDH, BUN, WBC, CPK, and D-dimer levels were significantly higher in those with worse outcomes. Oxygen saturation, CO2, and Platelets were lower in patients who died. Calcium levels were significantly lower in those with poor outcomes.

Conclusion: This study reinforces some known risk factors and challenges others. Elderly were at a higher risk of death compared to younger patients. There is a direct correlation between increasing age and fatality rate, but older age may correlate with increased comorbid medical conditions contributing to poor outcome. CHF showed the strongest relationship to fatality rate, which was nearly three times higher than those without CHF. Males and Black patients showed higher fatality rates than females and White patients. Contrary to current data, BMI alone may not be an independent variable for poor outcome. BMI correlates with diabetes, heart disease, and myocardial infarction rates and, if coexisting, may contribute to poor outcomes. Hypocalcemia, hypoxia, hypocarbia, and thrombocytopenia were seen more in patients who died but, clinical significance and correlation with disease process is unknown. Thus, further studies are needed to determine significance of these findings in relation to outcomes.