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that the number of ED patients diagnosed with PE and DVTs increased after the arrival of COVID-19.

Methods: Design: Retrospective cohort. Setting: 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. Population: Consecutive patients seen by ED physicians from March through November in 2019 and 2020, as COVID-19 arrived in this region in early March. Data analysis: We tallied the number of patients diagnosed with PE and DVTs using International Classification of Disease (version 10) codes. We computed the changes in visits from 2019 to 2020. We used chi-square to test for statistical significance, with alpha set at 0.05 using the Bonferroni correction for multiple comparisons.

Results: The database contained a total of 1,975,332 visits, 1,161,080 in 2019 and 814,252 in 2020 (a 30% decrease from 2019 to 2020). There were 3,552 and 2,529 patients diagnosed with PE and DVT respectively. The median age [interquartile range] and the percent female for PE and DVT were: 62 [48-72] and 62 [49-74]; 52% and 50% respectively. The number of visits for PE from March through November in 2019 and 2020 were 1,349 and 1,180, respectively. For DVTs these numbers were 1,977 and 1,575. Thus, visits for PE and DVT decreased from 2019 to 2020 by 20% and 13% respectively (p < 0.001).

Conclusion: Contrary to our hypothesis, we found that after the arrival of COVID-19 in the New York City area, visits for PEIs and DVTs did not increase. We speculate that ED visits in 2020 decreased due to public fears of exposure to COVID-19 infection during hospital visits. Furthermore, testing for diagnosis of PE and DVT was often deferred because of the challenges in performing these studies on patients under investigation for COVID-19 infection. These factors could explain the decrease in number of PE and DVT cases that we found, despite the possible increased incidence of these conditions in the population.

Risk Factors of Sepsis Among Patients With qSOFA<2 in the Emergency Department
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Study Objective: There have been concerns that some patients with sepsis—life-threatening organ dysfunction caused by a dysregulated host response to infection—may be overlooked with a quick Sequential Organ Failure Assessment (qSOFA)>2 in the emergency department (ED). Despite this, little is known about the risk factors associated with sepsis among patients with qSOFA<2 in the ED.

Methods: This is a retrospective cohort study using ED data from a large tertiary medical center in Japan 2018-2020. We included adult patients (aged ≥18 years) presenting to the ED with suspected infection (eg, having a fever) and qSOFA<2. The primary outcome was the diagnosis of sepsis based on the Sepsis-3 criteria (defined as septic patients). We compared patient characteristics (eg, demographics, vital signs upon the initial triage, chief complaint, and comorbidities) between septic and non-septic patients. Additionally, we identified the potential risk factors of sepsis among patients with qSOFA<2 using a multivariable logistic regression model.

Results: We identified 151 (7%) septic patients among 2,025 adult patients with suspected infection and qSOFA<2. Compared with non-septic patients, septic patients were likely to be older and have vital signs suggestive of imminent sepsis (eg, high respiratory rate). In the multivariable logistic regression model, the potential risk factors of sepsis among patients with qSOFA<2 were older age (adjusted OR, 1.92 [95% CI 1.19-3.19]), vital signs suggestive of imminent sepsis (eg, adjusted OR of altered mental status, 3.50 [95% CI 2.25-5.50]), receipt of oxygen therapy upon arrival at the ED (adjusted OR, 1.91 [95% CI 1.38-2.61]), chief complaint of sore throat (adjusted OR, 2.15 [95% CI 1.08-4.13]), and the presence of comorbid diabetes mellitus, ischemic heart disease, and chronic kidney disease (eg, adjusted OR of diabetes mellitus, 1.47 [95% CI 1.10-1.96]). On the contrary, high systolic blood pressure, and chief complaint of abdominal and chest pain were associated with a lower risk of sepsis (eg, adjusted OR of abdominal pain, 0.26 [95% CI 0.14-0.45]).

Conclusions: We found that older age, vital signs prognosticating sepsis, and the presence of some comorbidities were the potential risk factors of sepsis in patients with qSOFA<2. To prevent missed diagnoses of sepsis, we should treat patients with these potential risk factors more cautiously.