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.

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Results: During the study period, 11 patients with PE underwent mechanical thrombectomy with the IFTD. The cohort had a median age of 60 years (interquartile range [IQR], 47-65 years), with 7 of the 11 (63.6%) male, and the body mass index median was 34 kg/m² (IQR, 30-39 kg/m²). All the patients had right heart strain as the main indication for thrombectomy. Procedure median length was 45 minutes (IQR, 37-78 minutes), fluoroscopic time 10 minutes (IQR, 7-14 minutes), and radiation exposure 95.506 cGycm² (IQR, 83.642-194.528 cGycm²). There was 100% technical success, a thrombolytic drug was used in one patient (91%), 3 of the 11 (27.3%) required implantation of inferior vena cava filter, 5 (45.5%) patients were in the intensive care unit (ICU). 3 required 1 day in the ICU, 2 required 5 days in the ICU, and the rest of the patients who were not in the ICU did not needed ICU management after the procedure because of instability, and all patients (11/11 [100%]) experienced improvement in symptoms at the time of discharge. No complications or MAE were reported. Preprocedural median hemoglobin was 13 (IQR, 12-15) and before discharge was 12 (IQR, 10-14), glomerular filtration rate was 78 (IQR, 69-95), and before discharge was 89 (IQR, 82-101). Overall postprocedural length of stay was 3 days (IQR, 2-6 days).

Conclusions: Our initial experience with the IFTD for treatment of PE is promising and appears to be both safe and effective, with a 100% technical success rate. No MAE, low thrombolytic agents used, and short ICU utilization/postprocedural length of stay. Further studies are warranted, especially to evaluate this procedure against other approaches and long-term outcomes.

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A Tale of Two Surges: Improved Mortality During Second Wave of COVID-19 Infections
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Objective: Early publications have suggested higher venous thromboembolism (VTE) and mortality rates in patients with coronavirus disease-2019 (COVID-19), prompting the implementation of aggressive anticoagulation protocols to treat this high-risk cohort. In the United States, we experienced the first wave of the COVID-19 pandemic between March and May 2020, with a second wave arising between July and September. Our objective was to determine if there has been improvement in VTE and mortality rates within our health care network.

Methods: Institutional review board approval was obtained to review a prospectively maintained registry of COVID-19 patients treated within a large multihospital health care network. These patients were categorized into Surge 1 (admissions between March 1, 2020, and May 30, 2020) and Surge 2 (admissions between June 1, 2020, and September 13, 2020). Age, sex, race, ethnicity, comorbidities, intensive care unit (ICU) admission, VTE occurrence, readmission, and mortality data were obtained. Analyses were performed using SAS.

Results: Overall, 2552 patients with COVID-19 required admission to select hospitals within our health care system, with 33% requiring an ICU level of care. There were 920 (36.1%) patients admitted during surge 1. Patients admitted during surge 2 had shorter hospital lengths of stay, fewer readmissions, and lower mortality rates than those admitted during surge 1 (Table). VTE incidence was similar during surge 1 and surge 2 for all admissions (5.11% vs 4.84%; P = .764) and ICU admissions (8.57% vs 8.15%; P = .83). On multivariable analysis of all COVID-19 patients, VTE was independently associated with mortality (adjusted odds ratio, 4.60; 95% confidence interval, 3.41-6.20; P < .001).

Conclusions: Within our health care network, COVID-19 VTE and mortality rates are lower than previously reported global data, and mortality rates improved during surge 2. VTE development had over fourfold increased odds of mortality. These findings may be due in part to the aggressive anticoagulation strategies our health care network implemented based on lab findings, clinical suspicion, and diagnostic imaging. Future research should focus on determining who benefits most, and least, from anticoagulation protocols in order to reduce VTE in this hypercoagulable population.

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