Table. Revascularization outcomes

| Revascularization & N | Endovascular (N = 39) | Open (N = 24) | None (N = 11) | Overall (N = 74) |
|-----------------------|-----------------------|---------------|---------------|------------------|
| Age (years) mean (SD) | 65.1 (6.17)           | 60.8          | 62.2          | 62.2             |
| Diabetes mellitus     | 4 (36.4)              | 9 (37.5)      | 5 (45.5)      | 18 (39.1)        |
| Rutherford ALI scale  | I                     | 0 (0)         | 0 (0)         | 3 (6.5)          |
|                       | II                    | 0 (0)         | 0 (0)         | 4 (8.7)          |
|                       | III                   | 5 (45.5)      | 14 (58.3)     | 2 (18.2)         |
|                       | IV                    | 2 (18.2)      | 1 (4.2)       | 4 (36.4)         |

Successful revascularization rate was 41.3% with endovascular intervention, 50.0% with thrombectomy, 23.9% with endovascular lysis or thrombectomy, and 2.2% with routine medical management alone. The mean Vascu-Qol-6 on admission was 11.9 (standard deviation: 4.65), while the mean Vascu-Qol-6 on discharge was 12.8 (standard deviation: 4.65).

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 Vascu-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 = 59) with CLTI (dichotomized as ‘yes’ = 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. 97.8% White, and 49% were independently ambulatory (Table). Revascularization included bypass (46%), peripheral vascular intervention (25%), and femoral endarterectomy (21%). A total of 31% underwent minor amputation or wound debridement; 15% underwent major amputation, and no patients received medical management alone. The mean Vascu-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 (2.2 vs 2.7, P = 0.03). They also reported being less bothered by uncertainty regarding what to expect from the course of their illness (2.5 vs 3.4, P = 0.02). 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 = 0.10). Median length of stay was longer in the study group compared with the historic cohort (8 vs 7 days, P = 0.02). There was no difference in 30-day mortality (5% vs 8%, P = 0.42) 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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