

severe shortness of breath, and cough. Past medical history was significant for hypertension, poorly controlled insulin dependant diabetes, and obesity. She was admitted with COVID induced type 2 respiratory failure (pO₂ of 5.5 on 15L), DKA (ketones 2.1), AKI (Cr 163), and a hypercoagulable state (D-dimer >20 000). She was intubated and commenced on an insulin sliding scale, therapeutic anticoagulation, and antibiotics. On day 2 she became anuric, with CT-angio demonstrating thrombus extending from renal arteries down to the right popliteal artery. She underwent an embolectomy and 4 compartment fasciotomy and was started on renal replacement therapy. Unfortunately, her leg was not deemed viable, and due to persistent hyperkalaemia required amputation 2 days later. She continued to deteriorate despite maximal multiple organ support and was palliated 15 days later. CAC can have life-threatening sequelae, and patients with COVID-19 infection should be commenced on anticoagulation upon diagnosis.

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The coronavirus pandemic has overwhelmed healthcare systems worldwide, with more than 40 million affected and 1 million deaths. In addition to the typical symptoms, less clinically obvious was the underlying hypercoagulable state, termed COVID-19 associated coagulopathy (CAC). The exact mechanism of CAC is unknown, but it is suspected to involve all three aspects of Virchow's Triad: endothelial injury, stasis, and a hypercoagulable state. Here we report the case of a woman in her 60's who was admitted with COVID-19 and developed CAC with subsequent complications. She presented with a 3-day history of fevers,