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**Table.** Characteristics of Study Population

Variable	Positive block (n = 19)	Nonblock (n = 43)	p Value
Male, n (%)	1 (5.3)	8 (18.6)	> 0.05
Female, n (%)	18 (94.7)	35 (81.4)	> 0.05
Age, y, mean (SEM)	39.1 (3.6)	45.6 (2.9)	> 0.05
BMI, kg/m <sup>2</sup> , mean (SEM)	25.3 (1.3)	24.7 (0.91)	> 0.05
POTS diagnosis, n (%)	5 (26.3)	12 (27.9)	> 0.05

POTS, postural orthostatic tachycardia syndrome.

**RESULTS:** The cohort was dichotomized into block and nonblock groups (19 vs 43 patients) with symptom relief in 18 of 19 blocks. Primary outcomes analyzed were freedom from re-intervention and subjective symptom relief. There was a trend toward improved freedom from re-intervention (88.9% vs 81.4%) and subjective symptom relief (88.9% vs 74.4%) in the positive block group vs non-block group, although this was not statistically significant. Follow-up survey data (53.2% response) showed 90% of patients in the positive block group would have the operation again if given the option, vs 78.3% in the nonblock group.

**CONCLUSIONS:** We believe that celiac plexus block has predictive potential in the selection of patients for surgical intervention. Continued patient accrual and prospective research will aid in further characterization of its utility.

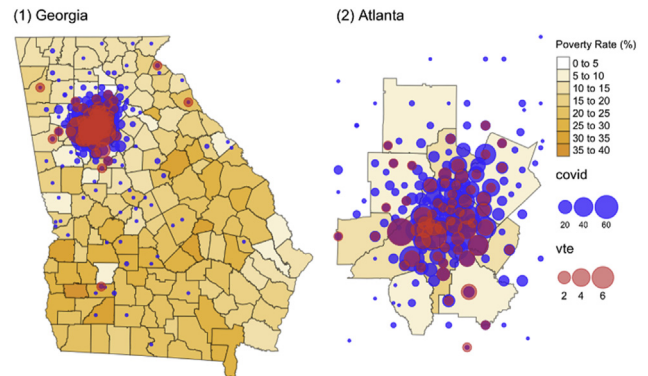
### County-Level Social Vulnerability Is Associated with Increased Risk for Venous Thromboembolism in COVID-19

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**INTRODUCTION:** Earlier literature primarily focuses on patient characteristics, sedentary behaviors, and laboratory biomarkers as predictors of venous thromboembolism (VTE). Although COVID-19 infection and hospitalization rates have been linked to social vulnerability, few studies have evaluated census-level data as they relates to risk for VTE development in COVID-19.

**METHODS:** A prospectively maintained registry of adult patients with COVID-19 admitted to a large academic healthcare network between March and September 2020 was reviewed. Data from our healthcare network and the Census Bureau were used to evaluate regression models.

**RESULTS:** There were 2,552 patients admitted for COVID-19-related illnesses during the study period. One hundred and twenty-six patients (4.9%) were diagnosed with a VTE. Black race ( $p = 0.042$ ), requirement for ICU care ( $p < 0.001$ ), requirement for mechanical ventilation ( $p < 0.001$ ), history of congestive heart failure ( $p < 0.001$ ), maximum D-dimer level ( $p < 0.001$ ), and maximum C-reactive protein level ( $p < 0.001$ ) were associated with VTE development. At the county level, there were higher rates of VTE in COVID-19 in counties with lower per-capita income ( $p = 0.03$ ), lower median family income ( $p = 0.009$ ), and 12-month



**Figure 1.** Geographic distribution of venous thromboembolism (VTE) occurrence in patients with COVID-19 treated within a large academic healthcare network, linked to county-level census data.

income less than the poverty level ( $p = 0.009$ , Fig. 1). Non-Hispanic/non-Latino ethnicity was also associated with VTE development in COVID-19 ( $p = 0.024$ ).

**CONCLUSIONS:** Black race and poverty were associated with increased VTE development among patients hospitalized with COVID-19. Attention to social determinants of health, in addition to biomarkers and clinical factors, should be given when considering COVID-19 associated VTE. Given a known independent association between VTE and mortality in COVID-19, optimizing prevention and/or expeditious treatment of vulnerable populations is imperative.

### Estimated Morbidity and Mortality after Open Abdominal Aortic Aneurysm Repair Is Underestimated in the American College of Surgeons NSQIP Database

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**INTRODUCTION:** The American College of Surgeons (ACS) NSQIP database reports surgeon quality by comparing a surgeon's observed morbidity and mortality to an expected morbidity (MORBPROB) and mortality (MORTPROB) using an estimation based on cases already within the database, commonly referred to as an observed to expected ratio. This study seeks to evaluate the validity of the ACS NSQIP MORBPROB and MORTPROB calculations for elective and emergent abdominal aortic aneurysm (AAA) repair.

**METHODS:** All patients undergoing open AAA repair in the ACS NSQIP-targeted AAA database from 2012 to 2019 were identified by ICD and CPT codes. We divided cases into elective and emergent groups and then stratified cases into quartiles based on MORBPROB and MORTPROB scores. We compared observed vs expected outcomes within each quartile in the elective and emergent groups. Cases were further stratified by proximal clamp location, and the observed vs expected outcomes were again compared.