

advancement in their careers. The Accreditation Council for Graduate Medical Education has recognized the reduction in patient volume in addition to the redeployment of training staff to support critical services.² Due to these changes, there is a concern among fellows that the time period away from the cardiac catheterization laboratory may impede their ability to hone their skill set.

In summary, there appears to be an overall decline in the number of cardiac catheterization laboratory procedures performed during the COVID-19 pandemic consistent with previously published studies 3 to 5.

Disclosures

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Prevalence and Outcomes of Acute Ischemic Stroke Among Patients ≤50 Years of Age With Laboratory Confirmed COVID-19 Infection

The COVID-19 epidemic has led to an unprecedented disruption in health care systems worldwide. Concerns have been recently raised about young patients with COVID-19 presenting with large ischemic strokes.¹ Data on stroke in COVID-19 patients remain

limited to a few case reports.¹ In this focused analysis, we investigated the incidence and outcomes of acute ischemic stroke in young adults using a multinational database.

We queried the TriNetx Research Network to select patients <50 years of age with laboratory confirmed COVID-19 infection between January 20, 2020 to April 24, 2020. Patients were identified as COVID-19 positive if they had a billable code for COVID-19 and had an associated positive laboratory confirmation of the infection (eTable-1). TriNetX is a global federated health research network providing access to statistics on electronic medical records (diagnoses, procedures, medications, laboratory values, genomic information) from patients in predominately large healthcare organizations. The TriNetx database (COVID-19 Research Network) is a network of 37 global healthcare organizations (36% based in the United States [US] and 64% outside of the US). The diagnosis of acute ischemic stroke was established via validated international classification of diseases 10th revision diagnosis codes.² Descriptive statistics were presented as frequencies with percentages for categorical variables and as mean ± standard deviation for continuous measures. Baseline characteristics were compared using a Pearson chi-squared test for categorical variables and an independent-samples *t* test for continuous variables. All-cause mortality was displayed in the 2 cohorts using the Kaplan Meier method, and statistical significance of the differences between the 2 groups were assessed with the Log-Rank Test.

A total of 9,358 COVID-19 positive patients age ≤50 years of age were identified in the database, of whom 33.2% were hospitalized for severe symptoms. The incidence of acute ischemic stroke was 64/9,358 (0.7%). Compared with patients who did not experience a stroke, those with acute ischemic strokes were older (39.3 ± 9.0 vs 36.7 ± 8.5 years, *p* < 0.001), but had similar proportions of females (60.9% vs 60.4%, *p* = 0.93). They, however, had higher prevalence of key comorbidities: hypertension (61.0% vs 11.7%); diabetes (32.8% vs 6.5%); heart failure (15.6% vs 1.5%), nicotine dependence (34.4% vs 5.9%); obesity (46.9% vs 17.4%); chronic obstructive



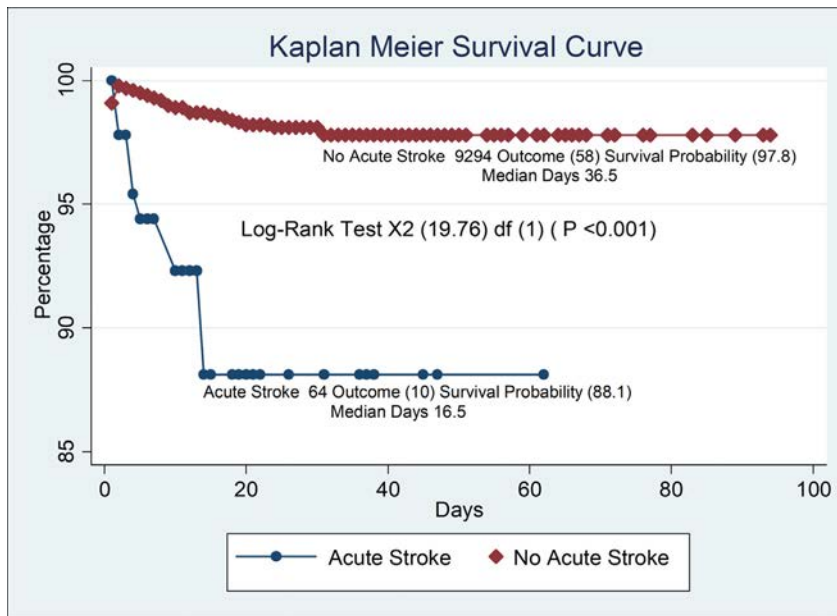


Figure 1. Kaplan meier survival analysis of young adults with COVID-19 with or without stroke.

lung disease (15.6% vs 1.0%); prior history of stroke (28.1% vs 0.5); and renal insufficiency (15.6% vs 2.0%), $p < 0.001$ for all. Median follow up was 16.5 days in the stroke cohort and 36.5 days in the no stroke cohort. All-cause mortality occurred in 10/64 patients (15.6%) in the stroke cohort vs. 58/9,294 patients (0.6%) in the no stroke cohort. In the Kaplan Meier survival analysis, patients with stroke had significantly lower odds of survival compared with those without stroke (p -log rank < 0.001) (Figure 1).

To our knowledge, this is the first study to report the incidence and outcomes of acute ischemic stroke in young adults with COVID-19 infection. We found a low overall incidence but a grim prognosis of acute ischemic stroke among unselected young adults with COVID-19. The findings of this analysis need to be interpreted in the context of its limitations. Due to the nature of this observational database, it is not possible to distinguish whether patients presented with strokes then tested positive for COVID-19 or vice versa. Also,

given the lack of a control arm without COVID-19, these findings cannot confirm an association between COVID-19 and increased risk of ischemic stroke especially with the higher prevalence of comorbidities in the stroke cohort.

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