medicine was consulted for all. The other 14 were transferred for observation before discharge home (mean total stay of 19.6h). Echocardiography was obtained for 3 patients (all transferred), with right ventricular dysfunction in 1, who was stable on discharge. Follow-up occurred on average within 6.3 days and within 14 days for 21. Two had 7-day PE-related hospitalizations: 1 for pain needing intravenous analgesia and 1 for enoxaparin allergy. There were no deaths.

**Conclusion:** One-third of gravid ambulatory adults with acute PE in this community setting were discharged home within 24 h. Care was multidisciplinary and often included service or location transfer. Seven-day PE-related hospitalizations were uncommon. Outpatient care of ambulatory PE patients appears feasible and safe but studies of larger cohorts in other settings are needed to better understand this understudied practice.

## 318 | Antenatal Pulmonary Embolism Diagnostics in Patients With COVID-19: A Retrospective Cohort Study

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**Background and Objectives:** The diagnostic evaluation of pulmonary embolism (PE) in pregnancy is challenging because the physiologic changes of pregnancy can mimic several PE symptoms. Concurrent COVID-19 may further complicate a clinician's PE diagnostic evaluation by increasing respiratory symptoms and augmenting the prothrombotic state. We examined how COVID-19 affects clinical presentation, PE pretest probability (using the pregnancy-adapted Geneva score), and diagnostic testing for PE in pregnant patients.

**Methods:** We performed a retrospective cohort study across 21 U.S. community medical centers from 10/1/2021 through 3/30/2023. We included pregnant outpatients ≥18 years evaluated for suspected PE with D-dimer testing, compression ultrasonography, computed tomography pulmonary angiography (CTPA), or lung scintigraphy. We excluded patients who had known PE or had early pregnancies that were still unrecognized. The COVID-19 cohort was identified by a positive polymerase chain reaction test in symptomatic patients obtained during the index evaluation or at home or a healthcare setting in the prior 5 days. We compared patients with and without COVID-19 using bivariate analysis.

**Results:** Among 860 eligible patients, median age was 30.0 years; 39.1% were in the third trimester. COVID-19 was confirmed in 147 (17.1%). Compared with non-COVID-19 patients, those with COVID-19 more often had fever (36.1% vs. 4.2%), tachycardia ≥110 bpm (66.0% vs. 34.2%), and oxygen saturation <95% (12.2% vs. 4.8%), but less often reported chest pain (49.7% vs. 65.5%) (all $p < 0.001$). Nearly all patients had low-to-intermediate pretest probability, but intermediate classification was more common in COVID-19 patients (63.3% vs. 39.0%; $p < 0.001$). COVID-19 patients more often had elevated D-dimer >1.0 mg/L (49.1% vs. 36.4%; $p < 0.001$) and more commonly underwent chest radiography (61.9% vs. 50.1%; $p = 0.004$). Among patients who underwent advanced imaging ($n = 393$), CTPA predominated in both cohorts. PE was diagnosed in 6 patients overall: 1 (0.7%) with COVID-19 and 5 (0.7%) without. Mortality was low overall ($n = 3$; 0.3%), occurring in 1 (0.7%) patient with and 2 (0.3%) without COVID-19.

**Conclusion:** COVID-19 in pregnancy was associated with a higher prevalence of abnormal vital signs, higher pretest probability, higher D-dimer values, and increased diagnostic testing, illustrating how concurrent COVID-19 may affect PE evaluation in pregnancy.

## 319 | Initial Emergency Department Blood Pressure and Acute Congestive Heart Failure Outcomes

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**Background and Objectives:** Congestive heart failure (CHF) may affect eight million Americans by 2030. These patients present to the Emergency Department (ED) with a wide range of initial blood pressure (BP), and the mainstay of therapy is diuretics. Our objective is to assess if presenting BP affects outcomes for CHF patients who receive diuretics in the ED.

**Methods:** We conducted a retrospective cohort study of a large health system from 2016 to 2022. We included ED-admitted CHF exacerbations with history of CHF and received ED diuretics. We excluded patients with history of aortic stenosis, SBP <90, need for inotropes/vasopressors, creatinine (Cr) >3, on dialysis, and missing data. Patients were divided based on triage BP. The Normal group included patients with systolic (SBP) of <120 or a diastolic BP of <80, Stage 1 included SBP ≥120 or DBP ≥80, Stage 2 included SBP ≥140–179 or DBP ≥90–119, and Hypertensive Crisis included SBP ≥180 or DBP ≥120. Primary outcome was hospital LOS and additional outcomes include readmission, mortality, ICU, BIPAP and AKI. Multivariable regression analysis was performed adjusting for age, sex, race, BMI, initial Cr, and Elixhauser Comorbidity Index and ED diuretic dosing.

**Results:** There were 10,129 patients identified of which 5515 were excluded, leaving 4614 for analysis. Patients fell into the following BP cohorts: Normal ($N = 1236$), Stage 1 ($N = 784$), Stage 2 ($N = 2055$), Hypertensive Crisis ($N = 539$); the median age was 76.0, 37.1% Black and 52.0% female. The LOS for both Stage 1 and Hypertensive Crisis patients was significantly decreased compared to Normal patients, with 8.5% reduction ($p = 0.012$) and 9.2% reduction ($p = 0.016$) respectively. Stage 2 had a 4.9% reduction in LOS that was not significant. Hypertensive Crisis patients saw a 24.9% reduction in readmission ($p = 0.025$), while other groups were reduced but not significant. Higher stages of HTN saw a large decrease in mortality. Stage 2 had 48.2% decreased mortality ($p = <0.001$), and Hypertensive Crisis had 64.5% decreased mortality ($p = 0.003$). ICU admission and AKI were not significantly different, however BIPAP usage was significantly higher in Stage 2 and Hypertensive Crisis categories.

**Conclusion:** In our cohort of ED CHF patients receiving diuretics, higher stages of presenting BP were associated with decreased LOS, readmission, and mortality. This may reflect