with most injuries occurring at industrial locations. Orbital floor fractures were the most commonly seen injury; accidental falls were the most commonly identified etiology. The in-hospital mortality was 2.8%.

**Examining Risk Factors for Trauma Patients in Acute Respiratory Distress Syndrome**

**CONCLUSION:** As seen in medical patients, sepsis and VAP/pneumonia are the two most common causes of Acute Respiratory Distress Syndrome (ARDS) in medical patients. Whether trauma patients have similar risk factors that lead to ARDS is unknown. We hypothesized that sepsis and pneumonia would be the biggest risk factors for developing ARDS for trauma patients.

**METHODS:** We utilized the American College of Surgeons Trauma Quality Improvement Program (TQIP) to identify patients ≥18 with Injury Severity Score (ISS) ≥16. Patients developing ARDS were compared to other trauma patients. Multivariate logistic regression was used to identify risk factors for ARDS.

**RESULTS:** A total of 364,222 patients met inclusion criteria, with 7,118 (2.0%) developing ARDS. ARDS patients were more likely to be a victim of drowning (26.4 vs. 59.3%, p < 0.001), burns (0.7 vs. 2.0%, p < 0.001) or have severe chest trauma (6.9 vs. 13.4%, p < 0.001). ARDS patients were more likely to be hypotensive on arrival (9.1 vs. 181%, p < 0.001), have sepsis (6.9 vs. 13.4%, p < 0.001), or pneumonia (4.6 vs. 34.7%, p < 0.001). On multivariate analysis, the biggest risk factors for developing ARDS included developing sepsis, ventilator associated pneumonia, and drowning. Other variables associated with ARDS included hypotension on presentation, burns, obesity, Black race, increasing age, and increasing ISS. Variables associated with decreased ARDS included being female and penetrating injury mechanism.

**CONCLUSION:** As seen in medical patients, sepsis and VAP/pneumonia are the biggest risk factors for developing ARDS in acutely injured trauma patients. Further studies are needed to determine if preventive measures may decrease ARDS in high risk patients.

**Food Access and Gun Violence**

**INTRODUCTION:** Gun violence in urban America occurs disproportionately in areas of concentrated disadvantage. These vulnerable areas are presumed to lack existing support infrastructure, including the availability of healthy food access. As a variety of negative health consequences have been linked to poor nutrition, we hypothesized that gun violence would disproportionately occur in areas with tenuous food access.

**METHODS:** A collaborative hospital and law enforcement database was utilized in order to determine residence of gunshot victims (GSV) from 2012-2018 in a single major metropolitan area. Census block groups are categorized into quintiles of healthy food access, based on food store density, transportation options, and area income. A Poisson regression is used to model the aggregate (2012-2018) GSV count in urban block groups as a function of food access, controlling for other relevant characteristics, including racial/ethnic composition, economic disadvantage, presence of young males, and square mileage.

**RESULTS:** A statistically significant relationship was demonstrated between food access and number of GSVs at the block group-level. Block groups in the three lowest food access categories have GSV counts that are 50% higher than block groups in the two highest categories. This association remains after controlling for the proportion of young males, the proportion black and Hispanic, the poverty rate, the vacancy rate, and the area size of the block group (pseudo R-squared = 0.49).

**CONCLUSION:** In an urban environment, neighborhoods with lowest access to healthy food were strongly associated with intentional firearm injury.

**General Surgeons’ Comfort and Urologists’ Perceptions of Bladder Trauma Management**

**INTRODUCTION:** The extent to which general surgeons (GS) and urologists collaborate on bladder trauma may vary by presentation and between institutions. We aim to assess factors influencing GS to involve urologists in the management of bladder trauma.

**METHODS:** Questionnaires containing eight bladder injury scenarios of increasing severity or complexity were distributed electronically to GS and urologists. GS were queried on their comfort level with each injury and likelihood that they would consult urology. Urologists were asked to provide their comfort level of GS managing each injury and likelihood that they would be consulted. Responses were graded on a Likert scale.

**RESULTS:** Questionnaire was completed by 108 GS and 104 urologists. While the perceived comfort of GS by urologists in