lesion and 86.2% had ≤ 3 lesions with a median = 2 cm (IQR 1–2). Lesions presented predominantly on upper limbs (40.9%), followed by lower limbs (23.2%). According to PAHO and WHO criteria, 18% (12.3% adult vs. 19.3%, P = 0.007) and 44.4% (adolescents 42% vs. adults 43%, P = 0.45), respectively, were eligible for local therapies.

**Conclusion.** Local therapies have feasible use in this population with mild and uncomplicated clinical presentation; however, its applicability is limited to current management criteria. Individualized risk—benefit assessment may increase eligibility.

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294. Follow-up Evaluation of Air Force Blood Donors Screening Positive for Chagas Disease

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**Session:** 50. Global Infections

**Thursday, October 5, 2017: 12:30 PM**

**Background.** Chagas disease, caused by the protozoan parasite Trypanosoma cruzi, is endemic to Texas and has significant morbidity associated with its cardiac presentation. The Joint Base San Antonio–Lackland (JBSA) represents a healthcare system with universal coverage to its beneficiaries and its blood bank screens all first-time blood donors for T. cruzi infection. Although there is a published, standardized approach for diagnosis and evaluation of Chagas disease in the United States, adherence to this approach has not been studied.

**Methods.** A retrospective chart review was performed on all persons who screened positive for T. cruzi on blood donation at JBSA from 2014 to 2016. Charts were reviewed to determine frequency and results of confirmatory testing, history and physical, EKG, and 30 second rhythm strip; outcomes of these evaluations were ascertained. Chagas disease was considered confirmed on the basis of positive EIA and TESA testing from the CDC and/or two different positive serologic tests.

**Results.** Of the 43,402 blood donors at JBSA, 23 screened positive for Chagas disease. Follow-up information was available on 22 (95.7%). Seventeen (77%) were military personnel and 18 (82%) were female. Patients had a mean of 2.5 (range 1–5) additional serologic tests, with 13 different combinations of confirmatory tests ordered, including IgG (77%) who had the initial screening test repeated. Two patients (9%), both from Texas, met criteria for Chagas disease. One of these was diagnosed with cardiac disease and underwent an investigatory screening test separation from the Air Force. Eleven (50%) had Chagas disease excluded on the basis of two negative follow-up tests, and 9 (41%) had one negative follow-up test. All underwent history and physical, 15 (68%) had an EKG, and 5 (22%) had a 30 second rhythm strip. Seventeen (64%) were referred to infectious diseases.

**Conclusion.** Among a small cohort of active duty service members who screened positive for T. cruzi infection on blood donation, diagnostic workup, and evaluation varied considerably, despite universal access to no-cost medical care within a single system. Opportunities exist within the military health system to examine heterogeneous and to improve evaluation of persons who screen positive in the future.

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295. Primary Care-Based Screening for Trypanosoma cruzi in High-Risk Populations: Results of the Strong Hearts Pilot in East Boston, Massachusetts

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**Background.** More than 300,000 people in the United States may be infected with Trypanosoma cruzi. This study describes the results of the Strong Hearts pilot project to integrate screening and facilitate referral for treatment for T. cruzi infection into primary care settings serving patients at high risk in Massachusetts.

**Methods.** We partnered with the Medicine, Pediatrics, Obstetrics, and Family Medicine divisions at the East Boston Neighborhood Health Center. Continuing education about Chagas disease was offered to healthcare providers, and community outreach to educate at-risk individuals and families was initiated. One-time screening for all patients under 50 years of age who lived in Mexico, South or Central America for at least 6 months was recommended. The initial screening test was an ELISA performed by a commercial laboratory. Confirmatory testing was performed at the Centers for Disease Control and Prevention (CDC) using serum saved at the health center laboratory. Patients with two positive tests were referred to the Infectious Disease Department of a partner institution for further evaluation and treatment.

**Results.** Three screening tests were ordered at the health center in the 3 months before the pilot. During the first 6 weeks of the pilot, participating providers ordered 203 screening tests. The patients screened included 90 (44%) women and 113 (56%) men; 90 (44%) were from El Salvador and 46 (23%) from Colombia. Thus far, results are available for 123 tests, among which 118 are negative and five are positive (one confirmed positive, one confirmed negative, and three pending). Two patients have been referred and treated for their disease.

**Conclusion.** The burden of Chagas disease may be underestimated even in facilities that serve high-risk patients. Our preliminary findings suggest that primary care-based screening for Chagas disease is feasible and embraced by providers and patients, and that it may improve the context of appropriate education and a seamless system for referral and treatment.

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