Conclusion. Our results indicate variation in practice among providers at ECU ID. Vaccine screening, the need for a follow-up, and the type of follow-up provided. Additionally, research shows that anal cancer is one of the non-defining AIDS cancers whose incidence increases as the patient ages. However, based on the data, anal cancer screening decreases as the patient ages at the ECU ID clinic. Therefore, a standardized clinic protocol is needed, which can help improve the screening rates.

Disclosures. All authors: No reported disclosures.

275. Parental Risk Factors for Fever in their Children 7-10 Days After the First Dose of Measles-Containing Vaccines
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Background. Fever 7–10 days after the first dose of a measles-containing vaccine (MCV) is one of the most common adverse events associated with vaccination. We aimed to determine the characteristics of parents associated with MCV-associated fever in children 7–10 days after MCV administration.

Methods. We conducted a cohort study including children born in Kaiser Permanente Northern California between 2009 and 2016 who received an MCV between ages 1 and 2 years. Each child was linked with his/her mother and father (if possible). We defined MCV-associated fever as a clinic or emergency department visit with fever code 7–10 days after the first dose of an MCV and identified parental clinical conditions present before or after child birth in electronic health record data. We evaluated parental clinical conditions associated with MCV-associated fever in the child using chi square or T test and multivariable logistic regression analyses.

Results. The study included 244,128 children, 192,253 mothers (100% of children’s mothers) (59% of children). There were 3,750 children (1.54%) with MCV-associated fever. We identified more than 1,000 separate clinical conditions in the parents, of which 29 maternal and 11 paternal conditions were significantly associated with MCV-associated fever in the child. After adjustment for maternal and infant conditions, rates including healthcare seek behaviors, maternal age and MCV (odds ratio, OR) of 1.18, 95% confidence interval [CI] 1.06–1.32), respiratory infection with fever (OR 1.20, 95% CI 1.10–1.31), maternal fever after a MCV (OR 5.90, 95% CI 1.35–25.78), migraines (OR 1.14, 95% CI 1.05–1.24), syncope (OR 1.14, 95% CI 1.01–1.27), arrhythmia (OR 1.21, 95% CI 1.00–1.45), essential thrombocythemia (OR 1.93, 95% CI 1.15–3.25) and Addison’s disease (OR 2.96, 95% CI 0.90–9.33) were significantly associated with infant fever after a MCV. Paternal fever (OR 1.44, 95% CI 1.20–1.72) and (OR 1.60, 95% CI 1.03–2.48) were associated with MCV-associated fever in the child.

Conclusion. Specific parental immune factors were associated with fever in their child. These results should be explored generally to genetics and particularly to familial immune responses.

Disclosures. N. P. Klein, Sanofi Pasteur: Investigator, Research grant. Merck: Investigator, Research grant. GSK: Investigator, Research grant. Pfizer: Investigator, Research support. Protein Science: Investigator, Research grant. MedImmune: Investigator, Research grant. Dynavax: Research Contractor, Grant recipient.

276. Immunogenicity of Takeda’s Bivalent Virus-Like Particle (VLP) Norovirus Vaccine (NoV) Candidate in Children From 6 Months up to 4 Years of Age
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Background. With the introduction of routine childhood rotavirus vaccination, norovirus is now becoming the major cause of medically-attended gastroenteritis in children. Takeda is developing a norovirus vaccine (NoV) that contains genotypes GI.1 and GII.4c and is formulated with PreV, a novel, self-assembling capsid protein that mimics natural virus-like particles (VLP). We report the immunogenicity data of NoV administered to children from 6 months up to 4 years of age.

Methods. Two age cohorts (1 to < 4 years, and 6 to < 12 months, n = 120 per cohort) were enrolled in this ongoing double-blind, randomized, phase 2 dose-finding study conducted in Colombia and Panama. Children received one or two intramuscular doses of NoV formulations containing 15/15, 15/50, 50/50 or 50/150 μg of GI.1 GI.4c VLPs with 0.5 mg Al(OH)3. Vaccinations were on Days 1 and 2, with saline placebo as dose two to maintain blinding in one dose groups. Antibody responses to each VLP were measured on days 1, 29 and 57 as functional histo-blood group antigen blocking antibodies (HBGA), expressed as seroresponses rates (SSR), the proportions displaying ≥ 2-fold increases over baseline, and geometric mean titers (GMT).

Results. Each formulation induced dosage-dependent HBGA responses after a single dose, with a further increase after a second dose. In 1- to <4-year-old HBGA SRR against GI.1 and GI.4c after one dose were 55–62% and 67–82%, respectively. SRR increased to 93–100% and 83–100% after a second dose. In 6 to <12 month-old responses were lower after the first dose: SRRs were 10–61% and 17–65% for GI.1 and GI.4c, respectively, increasing to 83–100% and 80–92% after a second dose. GMTs reflected this pattern of responses with higher GMTs for GI.1 and GI.4c achieved with the 50/150 μg formulation than the other dosages after both vaccinations in both age cohorts.

Conclusion. In 6–12-month-old infants and children up to 4 years of age, robust immune responses to the bivalent norovirus VLP vaccine candidates were observed; the highest HBGA responses in both age groups were observed after two doses of the 50/150 μg formulation. Further clinical evaluation of these formulations is underway in infants ≤ 6 months of age.

Clinical Trial Registration (NCT: 02135112, EndoCT: 2014-000779-20)

277. WInProgress: Epidemiological Changes After Tdap Maternal Immunization Strategy in a Pediatric Hospital
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Background. WInProgress is a major cause of morbidity and mortality in infants younger than 1 year old. In 2012 Argentina introduced Tdap in pregnancy to prevent infant mortality. The aim was to describe the clinical and epidemiological pro-o

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Methods. All laboratory PCR confirmed Bp cases between December 2003 and December 2017 were included in “R. Gutierrez” Children’s Hospital. Statistical analysis was performed comparing clinical epidemiological features, Bp hospitalization rates (per 10,000 discharges) and lethality rates (%), between pre-vaccination (PreV) 2003–2011 and post-vaccination maternal immunization strategy (PostV) 2013–2017 periods, excluding intervention year (2012).

Results. The numbers of cases were 350 (23.6%) were Bp confirmed cases; median age 3 months (Q = 2–7 months), 38% <3 months, 68% <6 months, 83% <12 months; 55% females; 18 had comorbidities; prematurity 10%, malnourishment 1%, and immunosuppression 1%; 81% required hospitalization, median length of stay was 6 days (4–10 days); 17% in UCI. Confirmed cases showed a seasonal pattern predominantly from September through February (spring–summer). In comparison with PreV, PostV cases were older (3 vs. 9 months; P < 0.001), required less hospitalization (87% vs. 68%; P < 0.001), HR (2.23 vs. 10.9; P < 0.001) and LR (6.86% vs. 0%; P = 0.03) decreased and had a higher proportion of complete primary vaccination schedule. Hospitalization and lethality rates showed a significant decrease. There were no fatal cases occurred in PostV.

Conclusion. After maternal immunization strategy Bp confirmed cases were older, had less hospital and required less hospitalization, had a higher proportion of complete primary vaccination schedule. Hospitalization and lethality rates showed a significant decrease. There were no fatal cases in our center after this intervention.

Disclosures. All authors: No reported disclosures.

278. Maternal Immunization Rates With Tetanus–Diphtheria–Acellular Pertussis and Influenza Vaccines in the United States: A Retrospective Claims Database Analysis
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Background. The Advisory Committee on Immunization Practices (ACIP) recommends maternal immunization (MI) with tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap) vaccine during every pregnancy; preferably between 27–36 weeks of gestation, as well as influenza vaccination for all women who are pregnant or who might be pregnant in the influenza season.

Methods. This retrospective cohort analysis characterizes the rate of Tdap and influenza vaccination among large national samples of pregnant women in the United States, and compared MI rates across different populations. MI rates were calculated using administrative claims data from the MarketScan Commercial Claims and Encounters (“Commercial”) and the Multi-State Medicaid Databases (“Medicaid”) were used to identify pregnancies between January 1, 2010 and April 30, 2017. Diagnosis and procedure codes that describe gestational age at pregnancy end were used to estimate the date of last menstrual period (LMP) or the index date (Figure 1). Eligible pregnancies had 26 weeks of continuous enrollment prior to index date