282. Epidemiology of Candidemia in Patients with Solid Tumors of the Gastrointestinal Tract
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Background. The Gastrointestinal (GI) tract is considered as an important source of candidemia. Numerous studies indicate that the majority of patients with candidemia and cancer have an underlying solid tumor mostly of the GI tract. Widespread use of antifungal prophylaxis among patients with selected hematological malignancies resulted in a proportional redistribution of the frequency of candidemia among patients with various malignancies, but the incidence of candidemia among patients with GI solid malignancies is unknown.

Methods. A retrospective chart review of patients diagnosed with GI malignancies from 2010 to 2018 at Rochester Regional Health, Lipson Cancer Institute was conducted, and the incidence of candidemia was determined.

Results. A total of 2783 patients with GI malignancies were analyzed. Fifty-six percent were males, and a mean age was 67 years. Sites of malignancy included large intestine (n = 1269), pancreas (n = 394), any part of the mouth and associated organs (n = 282), liver and biliary system (n = 273), stomach (n = 235), esophagus (n = 135), small intestine (n = 110), and others (n = 85). Over the period of review, total mortality was 49%. Only 0.7% (n = 19) patients developed candidemia, with a total of 22 events. Nine episodes of candidemia happened prior to diagnosis of cancer, and 13 episodes developed after or at the time of diagnosis. There was no commonality in GI solid malignancy site among patients with candidemia. C. albicans was the most common isolate (9 episodes), followed by C. parapsilosis (8), C. glabrata (3), and C. dubliniensis (2). At the same time, there were 273 episodes of bacteremia in 230 patients (8%).

Conclusion. In our study candidemia among patients with GI solid-organ malignancies was very rare.

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283. Potentially Achievable Hepatitis A Vaccination Coverage with Simultaneous Administration of Vaccines Among Young Children in the United States
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Background. The Advisory Committee on Immunization Practices recommends simultaneous administration of all age-appropriate doses of vaccines. We estimated the vaccination coverage for ≥2 doses of hepatitis A vaccine (≥2 HepA) that could have been achieved if opportunities for simultaneous administration with other recommended childhood vaccines had not been missed.

Methods. We analyzed National Immunization Survey-Child data for 2008–2017 in the United States. We defined potentially achievable ≥2 HepA coverage by age 24 months as the possible coverage if opportunities for simultaneous administration with other age-appropriate doses of vaccines for children by age 24 months had not been missed. We compared potentially achievable vaccination coverage to reported ≥2 HepA vaccination coverage by birth years 2007 to 2015. For children born in 2015, we stratified estimates by state and by selected socio-demographic factors. Both potentially achievable and reported ≥2 HepA coverage were evaluated using a Kaplan–Meier survival procedure to account for censoring of vaccination status.

Results. Compared with reported vaccination coverage, potentially achievable coverage for ≥2 HepA was at least 10 percentage points higher across birth years 2007 to 2015 and would have surpassed the 85% target of Healthy People 2020 for children born in 2015 (Figure 1). For the 2015 birth cohort, potentially achievable ≥2 HepA coverage exceeded the 85% Healthy People 2020 target in ten states (Figure 2). In addition, potentially achievable vaccination coverage was higher than reported coverage across all selected socio-demographic factors, with differences ranging from 20.1 percentage-points (private insurance only) to 31.7 percentage-points (non-Hispanic Black) (Table 1).

Conclusion. Potentially achievable coverage with ≥2 HepA consistently exceeded reported coverage for children from nine recent birth cohorts and across all selected socio-demographic characteristics. Coverage could increase substantially if missed opportunities were eliminated. Evidence-based interventions such as establishment of standing orders, use of provider reminders, and use of immunization information systems are recommended to increase HepA coverage among young children.

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284. Using Epidemiologic Investigation and Viral Sequencing to Describe and Prevent Public Health Response to an Outbreak (OB) of Acute Hepatitis A Virus Infection (HAV) in the San Fernando Valley (SFV), California
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Background. In October and November 2018, we identified a cluster of three HAV cases among persons linked by drug use and homelessness in the San Fernando Valley (SFV), CA. We describe how molecular epidemiologic methods linked an additional four OB cases that lived or were associated with a senior housing facility (SHF) and guided hepatitis A vaccine outreach.

Results. We identified 7 HAV cases with symptom onsets from October 2018 to January 2019. All 7 cases had positive serum HAV IgM and were epi-linked to a case previously identified. Of 3 homeless cases, 2 had genotype IB, CA cluster A; one specimen was unavailable. Four additional SHF cases were 2 residents, one of whom was a visitor. Among the 4 cases associated with the SHF, three had genotype IB, CA cluster A; one specimen was unavailable. Two elderly residents reported severe fatigue, without nausea, diarrhea and vomiting. Among the 3 homeless individuals, no direct link to the SHF was established. In total, 948 HAV vaccines were provided at the SHF, homeless shelters and other settings. HAV vaccine coverage for SHF residents and food handlers was 70% and 62%, respectively.

Conclusion. Two clusters of HAV cases were identified among homeless persons and individuals associated with an SHF were linked through a common HAV genotype. Two elderly cases had atypical symptoms that may not have been confirmed as HAV without viral sequencing and prompted vaccine campaign to prevent additional HAV cases.

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Table 1. Potentially achievable vs. reported vaccination coverage and 95% confidence intervals for ≥2 doses HepA by age 24 months, by selected socio-demographic factors, for children born in 2015, National Immunization Survey-Child, United States

| Factors | Categories | Reported Coverage % (95% CI) | Potentially Achievable Coverage % (95% CI) |
|---------|------------|-----------------------------|-------------------------------------------|
| National | Private Only | 61.7 (59.4-64.1) | 85 (83.5-86.6) |
| Children health insurance status | Any Medicaid | 68.2 (64.7-71.7) | 88 (83.0-90.1) |
| | Other | 57.3 (52.9-61.6) | 83 (80.0-85.9) |
| | Other | 56.9 (50.6-63.4) | 83 (73.7-90.5) |
| | uninsured | 52.5 (45.2-59.7) | 61 (54.8-74.9) |
| | Non-Hispanic White | 61.9 (58.6-65.1) | 84 (80.1-87.6) |
| | Non-Hispanic Black | 68.6 (64.5-72.4) | 78 (72.5-84.1) |
| | Hispanic | 64.6 (58.7-70.3) | 87 (80.4-90.5) |
| | Other | 67.6 (60.0-74.7) | 90 (86.0-93.1) |
| Family poverty level | Above Poverty | 63.9 (61.1-66.7) | 78 (80.5-88.9) |
| | Below Poverty | 65.6 (62.1-69.2) | 81 (74.7-87.4) |
| Residence in a metropolitan statistical area | MSA, Principal City | 30.4 (26.9-34.0) | 38 (35.0-41.0) |
| | MSA, Non-Principal City | 30.6 (32.6-34.6) | 38 (37.0-40.6) |
| | Non-MSA | 25.5 (21.6-29.3) | 31 (28.0-34.0) |
| Mother’s education level | <12 years | 43.5 (37.8-49.5) | 50 (47.0-53.0) |
| | 13-15 years | 53.9 (44.8-63.0) | 61 (57.0-66.0) |
| | 16 years or more | 57.6 (51.8-63.6) | 65 (61.0-69.6) |
| Mother’s marital status | Married | 65.6 (62.4-68.8) | 86 (83.5-88.5) |
| | Not married | 51.6 (47.8-55.6) | 70 (67.4-73.6) |
| Mother’s age | Age <20 years | 57.4 (53.1-61.8) | 73 (69.0-77.6) |
| | ≥30 years | 64.2 (61.1-67.4) | 85 (80.3-90.7) |
| Family mobility since birth from different state | Moved | 37.4 (34.8-40.1) | 79 (76.3-81.5) |
| | Not moved | 62.5 (59.6-65.0) | 85 (80.4-90.7) |
| Child’s birth order status | First Born | 59.6 (55.7-63.6) | 84 (80.1-89.6) |
| | Not First Born | 57.5 (53.1-61.9) | 79 (75.3-83.9) |
| Vaccination provider type | Private | 54.4 (47.6-61.2) | 71 (67.0-76.6) |
| | Other | 61.6 (57.3-65.9) | 85 (80.3-88.0) |
| | Private | 64.6 (61.1-68.4) | 86 (84.0-88.2) |
| Number of providers | 1 provider | 63.5 (59.6-67.5) | 86 (83.7-87.4) |
| | 0 provider | 63.5 (59.6-67.5) | 86 (83.7-87.4) |
| Number of vaccinations provided for child | >2 providers | 59.2 (54.4-64.1) | 80 (75.8-85.9) |
| | 1 provider | 64.6 (61.1-68.4) | 86 (84.0-88.2) |
| Number of children in household | ≥2 | 67.6 (62.9-72.6) | 88 (83.5-90.7) |

Note: All comparisons between potentially achievable vs. reported vaccination coverage are significant at P < 0.001.

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285. Fibrosis Progression and Clinical Outcomes in HCV/HBV Coinfected Persons in the ERCHIVES Cohort
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Background. Progression of liver disease and clinical outcomes in HCV/HBV coinfected persons and how they differ from HCV monoinfected persons and HCV inflected persons with resolved HBV infection are not well characterized. We compared incidence of cirrhosis, hepatic decompensation and overall mortality in these three groups.

Methods. Using the Electronically Retrieved Cohort of HCV-infected Veterans (ERCHIVES), we identified those with HCV infection only, HCV/HBV coinfection (HbsAg or HBV DNA or both positive) or HCV with resolved HBV (HbsAb+ in absence of HbsAg or HBV DNA positivity). We excluded those with HCV hepatocellular carcinoma at or before baseline, and those who received any HCV or HBV treatment. Incident rates (95% CI) were determined for cirrhosis, first hepatic decompensation event and overall mortality in the three groups.

Results. We identified 60,368 HCV monoinfected (Gp A), 151 HCV/HBV coinfected (Gp B) and 19,802 HCV infected with resolved HBV infection (Gp C). Mean age was 61.0, 60.9 and 63.0 years in the three groups and 96.5%, 96.0% and 94.8% were male, respectively. Incident cirrhosis (among those without cirrhosis at baseline) was increased 2.5-fold in HCV/HBV coinfected persons compared to HCV monoinfected persons and HCV-infected persons with resolved HBV infection. Among those with cirrhosis at baseline, the difference was small among HCV/HBV coinfected and the other groups.

Conclusion. HCV/HBV coinfected persons with minimal or mild/moderate fibrosis at baseline have a much higher risk of developing cirrhosis, hepatic decompensation and mortality. However, once cirrhosis has is established, the difference is diminished. This underscores the need to intervene early when HCV/HBV coinfected persons still have minimal or mild/moderate fibrosis.

Table. Incidence rates (per 1,000 patient years of follow-up) for cirrhosis, hepatic decompensation and overall mortality

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