were 70.97% (95%CI 58.05%-81.80%) and 56.32% (95%CI 45.26%-66.94%) respectively. While for Fluorospot, the AUROC was 0.906 (95 CI 0.856-0.957), the sensitivity and specificity of differentiating ATB from LTBI were 80.65% (95%CI 68.63% - 89.58%) and 88.51% (95%CI 79.88% - 94.35%) respectively.

Conclusion. Compared with T-SPOT.TB, the IFN-γ/IL-2/TNF-α-Fluorospot assay may be helpful to distinguish ATB from LTBI, and the results need to be verified by large sample prospective cohort study.

Disclosures. All Authors: No reported disclosures

1406. Hepatitis B and C Prevalence in Patients with Active and Latent Tuberculosis in an Ethnically Diverse Area of London, UK
Amedine Durut, MBBS BA (Hons)1; Emma Thorley, MBBS BA (Hons)1; Ayolola Eni-Orlota, n/a2; Oushi Siddar, BSc3; Padmasayy Papineni, MBChB3; 1London North West University Healthcare NHS Trust, London, England, United Kingdom; 2Imperial College London, London, England, United Kingdom
Session: P-80. Tuberculosis and other Mycobacterial Infections
Background. The prevalence of chronic HBV in the study population was higher than the estimated UK prevalence. Fifteen diagnoses of hepatitis were new, allowing specialist referral for monitoring of fibrosis and development of hepatocellular carcinoma. Three patients required hepatitis treatment. 6.8% of patients were positive for anti-HBc and therefore identified as being at future risk of HBV reactivation if requiring immunosuppressive therapies. Disproportionately affects marginalised communities; screening for viral hepatitis in TB clinic represents an opportunity to target these hard-to-reach groups to maximise the impact of public health interventions.

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1407. The Latent Tuberculosis Infection Cascade of Care during the COVID-19 Pandemic Response in a Mid-Sized US City
Trevor M. Stanifl, BS1; Lauren Houshel, BS2; Rinki Goswami, MD1; Serenity Millow, BA3; Gabrielle Cook, n/a3; Robin Knapmeyer, RN4; Christa Easton, RN4; Jennifer L. Mooney, PhD5; Moises A. Haasman, MD, MS5; 1University of Cincinnati, Cincinnati, Ohio; 2Hamilton County Public Health, Cincinnati, Ohio
Session: P-80. Tuberculosis and other Mycobacterial Infections
Background. The COVID-19 pandemic response may unintentionally disrupt multiple public health services, including tuberculosis control programs. We aimed to assess the cascade of care of latent tuberculosis infection (LTBI) in an urban US city during the COVID-19 pandemic response.

Methods. We conducted a retrospective cohort study of adult patients who presented for LTBI evaluation at the Hamilton County Public Health Tuberculosis Clinic in Ohio between 2019 and 2020. We defined 01/2019 to 02/2020 as the pre-COVID-19 response period, and 04/2020 to 12/2020 as the COVID-19 pandemic response period. We reviewed electronic medical records and extracted sociodemographic information, medical history, and follow-up and treatment data to define steps within the LTBI cascade of care. Logistic regressions were used to assess factors associated with LTBI treatment acceptance and completion, adjusted by potential confounders and COVID-19 period.

Results. Data from 312 patients were included. There was a significant decrease in the number of monthly LTBI referrals (median, 18 vs. 8, p=0.02) and LTBI evaluations (median, 17.5 vs. 7, p=0.01) during COVID-19. There was a decrease in the proportion of patients for whom LTBI testing (50% vs. 9%; p=0.01), and an increase in LTBI diagnoses based on interferon-gamma release assay (IGRA) (30% vs. 49%; p=0.01) during COVID-19. The proportion of people who were recommended LTBI treatment was similar before and during COVID-19 (76% vs. 81%, p=0.41), as well as the LTBI treatment acceptance rates (56% vs. 64%, p=0.26), and LTBI treatment completion rates (65% vs. 63%, p=0.85). In multivariable analysis, LTBI treatment acceptance was associated with Hispanic ethnicity, younger age, male sex, IGRA use, no comorbidities, and non-healthcare occupation, independent of COVID-19 period. LTBI treatment completion was associated with taking a rifampin-containing regimen, independent of COVID-19 period.

Conclusion. We observed a significant decline in the number of monthly LTBI referrals and evaluations during COVID-19. Our findings indicate an unintended negative impact of the COVID-19 response in LTBI screening efforts in our region. LTBI treatment acceptance and completion rates were not affected during COVID-19.

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1408. Population-based Nontuberculous Mycobacteria Surveillance in Four Emerging Infections Program Sites, October 2019–March 2020
Kelly A. Jackson, MPH1; Devra Barter, MS5; Christopher A. Caza, MD, DrPH1; Helen Johnston, MPH1; Ruth Lynfield, MD2; Ruth Lynfield, MD2; Paula Snappes Vagnone, MT(ASCP)3; Laura Tourout, MPH1; Nancy Spina, MPH1; Chiwina Dumayti, MD4; Shantel Peters, MPH1; Gabriela Escutia, MPH1; Rebecca Pierce, PhD, MS, BSN7; Emily Henkle, PhD, MPH1; D Rebecca Prevots, PhD, MPH1; Max Salinger, MD5; Kevin L. Winthrop, MD, MPH1; Kevin L. Winthrop, MD, MPH1; Nadege Charles Toney, MS5; Shelley Magill, MD, PhD1; Cheri Grigg, DVM, MPH1; 1Centers for Disease Control and Prevention, Atlanta, GA; 2Colorado Department of Public Health and Environment, Denver, Colorado; 3Minnesota Department of Health, St. Paul, MN; 4Minnesota Department of Health Laboratory, St. Paul, MN; 5New York State Department of Health, Albany, NY; 6New York Rochester Emerging Infections Program at the University of Rochester Medical Center, Rochester, NY; 7Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention, Atlanta, Georgia
Session: P-80. Tuberculosis and other Mycobacterial Infections
Background. Nontuberculous mycobacteria (NTM) cause pulmonary (PNTM) and extrapolmonary (ENTM) disease. NTM infections are difficult to diagnose and treat; environmental exposures occur in both healthcare and community settings. Few population-based studies describe NTM disease epidemiology. Current data indicate PNTM disease and ENTM skin and soft tissue infections are increasing. We describe findings from a multi-site pilot of population-based NTM surveillance.