Conclusion. The early adoption of universal HCV screening in adults (prior to 2020 USPSTF update) at an urban FQHC, together with an initiative to provide multidisciplinary HCV care at this FQHC (Figure 1), led to increasing rates of ordered screening. The presented 6-month data does not fully account for lag times between test ordering and fulfillment, resulting in under-reporting of universal HCV screening rates. Multidisciplinary care models to address HCV in patients’ medical homes are vital to HCV eradication with the robust implementation of universal HCV screening a vital first step in this continuum.

Disclosures. Deborah A. Kahal, MD, MPH, FACP, Gilead (Speaker’s Bureau)

919. Rates of False-Positive Hepatitis B Surface Antigen Is Low in Cancer Patients
Joseph Klingens, MD1; Marcel Yibirin, MD2; Jessica P. Hwang, MD, MPH1; Harry A. Torres, MD3; M.D. Anderson, Houston, Texas; 1Departments of Infectious Diseases, Infection Control and Employee Health, Houston, Texas; The University of Texas MD Anderson Cancer Center, Houston, TX

Session: P-52 Hepatitis

Background. Accurate interpretation of hepatitis B virus (HBV) laboratory testing is paramount in avoiding inaccurate diagnosis and incorrect management that could lead to unnecessary and overtreatment. This is particularly relevant in patients with cancer where universal testing is recommended in order to avoid HBV reactivation. Hepatitis B surface antigen testing (HBsAg) positivity indicates chronic or acute HBV infection. The rates and outcomes of a false-positive HBsAg have not been established for patients with cancer.

Methods. Three hundred and ninety-seven patients with any type of cancer and positive HBsAg testing were seen at MD Anderson Cancer Center from January 2016 – January 2021 were retrospectively reviewed in this study approved by the institutional review board. Cases of false-positive HBsAg were defined as those patients with a positive HBsAg but negative HBsAg quantitative, negative HBV core antibody (total Ig), and undetectable HBV DNA within 30 days of positive HBsAg testing. Serum samples from patients were tested for HBsAg using Vitros Enhanced Chemiluminescent Immunoassay (Ortho-Clinical Diagnostics, Raritan, NJ, USA). Data collection includes demographics, past medical history, underlying cancer and its stage, prior cancer treatment, risk factors for HBV, co-infections (HCV, HIV), symptoms, liver function tests, anti-HBV treatment, and interruptions on cancer treatment.

Results. Out of 397 patients with a positive HBsAg, 33 were excluded as they did not meet the diagnostic criteria or have insufficient HBV data. Of them, 3 cases (0.8%) were identified as false-positive HBsAg. All 3 patients were female, white, and had progressive malignancy (Table 1). No prior history of liver disease or liver function abnormalities were noted with these 3 patients. Initially, antiviral treatment was started on 1 patient which was discontinued shortly after confirmation of false-positive HBsAg. All 3 patients had additional workup and evaluation by an HBV specialist. In 2 patients, cancer treatment was canceled or delayed.

Table 1. General characteristics of patients with false-positive HBsAg

| Characteristics | Patient 1 | Patient 2 | Patient 3 |
|----------------|----------|----------|----------|
| Age (y)        | 76       | 66       | 45       |
| Sex            | Female   | Female   | Female   |
| Race           | White    | White    | White    |
| Cancer type    | MDS      | MDS      | MDS      |
| Cancer stage   | N/A      | N/A      | N/A      |
| Progressive cancer | Yes     | Yes     | Yes     |
| HBsAg          | Reactive | Reactive | Reactive |
| HBsAg quant (IU/mL) | Negative | Negative | Negative |
| HBV DNA quant (IU/mL) | Undetectable | Undetectable | Undetectable |
| HBcAb total    | Negative | Negative | Negative |
| HBcAb          | Negative | Negative | Negative |
| HBe Ab         | Negative | Negative | Negative |
| HBV Ag         | Negative | Negative | Negative |
| HBV 4th generation | Positive | Positive | Positive |
| ALT (U/L)      | 25       | 9        | 17       |
| AST (U/L)      | 20       | 19       | 20       |
| Absolute neutrophil count (K/uL) | 3,710 | 9,730 | 3,092 |
| Need for HBV specialist | Yes | Yes | Yes |
| Chemotherapy delay or cancellation | No | Yes | No |

Disclosures. Deborah A. Kahal, MD, MPH, Gilead (Speaker’s Bureau)

920. Automated Hepatitis C Screening and Linkage to Care Among Hospitalized Patients Born Between 1945-1965
Julia A. Gassor, n/a1; Rebecca Rouliff, LPN2; Vincent Lo Re III, MD, MSCE3; Anne Norris, MD4; Sheneylah Bennett, n/a2; Nancy Aitchison, MD2; Nicole Ferrante, MD2; Chalanda Evans, MPH1; Mitsuh Patel, MD, MBA1; Shivan Mehta, MD, MBA, MSPH2; Jesse Torgersen, MD, MHS, MSCE1; Perelman School of Medicine, Philadelphia, Pennsylvania; 1University of Pennsylvania Health System, Philadelphia, Pennsylvania; 2University of Pennsylvania, Philadelphia, PA; 3Penn Presbyterian Medical Center, Philadelphia, Pennsylvania; 4Perelman School of Medicine, University of Pennsylvania Health System, Philadelphia, Pennsylvania

Session: P-52 Hepatitis

Background. Hepatitis C virus (HCV) infects 4.1 million people in the United States, of whom 50% are unaware of their status. In 2016, Pennsylvania introduced a law mandating HCV screening for patients born between 1945-1965 in inpatient settings. However, HCV screening during hospital admissions has remained low in part due to limited knowledge on HCV testing requirements, interpretation of results, and treatment approaches. To overcome these barriers, we implemented a quality improvement initiative to automate HCV screening as part of hospital admission order sets, facilitate linkage to HCV treatment, and sought to evaluate its effectiveness.

Methods. Between September 2020 and May 2021, the automated inpatient HCV screening strategy was implemented at a single 328-bed academic hospital in Philadelphia, PA. Patients born between 1945-1965 without documentation of HCV screening or diagnosis in the electronic medical record had a HCV antibody with reflexive confirmatory RNA assay automatically populated in the admission order set. Admitting providers could opt out of the screening as appropriate. All patients with reactive HCV antibody were approached by the Hepatitis Linkage Team for result disclosure, counseling, and linkage to treatment for those with HCV viremia. Cascade of care was detailed for those linked to providers within the health system.

Results. During the initial 8 months of the program, 2,203 patients were screened for HCV, identifying 156 with reactive HCV antibody (7.1% seroprevalence). Among 147 with completed HCV RNA assay, 31 were viremic (21.4%). Fourteen viremic patients were not linked to care, including six with a terminal illness, two who declined linkage, and six who did not respond to linkage attempts. Nine were linked to care at other health systems. Among the 28 patients linked to providers in the health system, 21 (75%) completed initial visits. 42.8% were prescribed direct acting antivirals (DAAs), and 21.4% completed therapy by May 2021. One person achieved sustained virologic response 12 weeks after treatment as of May 2021 (Figure 1).

Conclusion. Automated inpatient HCV screening is a viable strategy to identify people with HCV and facilitate linkage to care. Optimal strategies to ensure patients access and maintain care require further study.

Disclosures. Jessica P. Hwang, MD, MPH, Merck (Grant/Research Support)

921. Acute HAV Infection in an Inpatient Psychiatry Unit
Gregory Weston, MD, MScCR1; Carmel Boland-Reardon, RN2; Renee Rhodes, RN/BN; Julis A. Ogbonna, FNP BC3; Suksha Strickland, MBRSS; Inessa Gendlinga2; Inessa Gendling3; Mariliou Corpuz, MD2; Montefiore Medical Center and Albert Einstein College of Medicine, Bronx, New York; 2Montefiore Medical Center, Bronx, NY; Albert Einstein College of Medicine, Bronx, NY

Session: P-52 Hepatitis

Background. Although uncommon, cancer patients with false-positive HBsAg need further workup to avoid overtreatment and unnecessary interruptions in cancer care.

Conclusion. Although uncommon, cancer patients with false-positive HBsAg need further workup to avoid overtreatment and unnecessary interruptions in cancer care.

Disclosures. Jessica P. Hwang, MD, MPH, Merck (Grant/Research Support)
Methods. A patient was admitted on 3/21/21 from a group home. He developed abdominal pain, diarrhea and vomiting on 4/15, with elevated liver function tests (LFT). He was transferred to Medicine on 4/17 and HAV IgM and IgG resulted positive on 4/18. Visitation to the unit has been halted for over a year, and no outside food has been allowed. The patient has not been observed to have any sexual exposure to others. Exposure window: 15 days prior to start of symptoms. Patients in the unit were screened for symptoms, tested for HAV IgM/IgG, LFTs. Discharged patients were contacted and referred straight for vaccination (difficult to have multiple visits). Staff members with contact to the unit were screened, via email and phone calls. If no previous vaccination and there was presence of exposure or symptoms, staff were referred to Occupational Health Services (OHS). Other Measures: The unit was terminally cleaned and daily enhanced cleaning with bleach ensued. Daily assessment of patients and staff for symptoms. Admissions were held for 2 days until all the patients were tested and given vaccine. Follow-up sessions were screened for HAV.

Results. 32 inpatients screened. One patient was positive for HAV IgM, but was asymptomatic with normal LFTs. On investigation, patient had acute hepatitis in February 2021. Patients with no immunity were vaccinated. Two immunocompromised patients were also given HAV immunoglobulin. On chart review, 6 out of 29 discharged patients had evidence of immunity; 133 staff were screened and 54 referred to OHS (see table).

Exposure Investigation

| Total | IgM | IgG Pos | IgG Neg | Normal | Vaccinated by OHS | HAV immunoglobulin |
|-------|-----|---------|---------|--------|-------------------|-------------------|
| Inpatients | 32 | 24 (75%) | 8 (25%) | 1 | 31 | 6 |
| Discharged | 29 | N/A | 6 | N/A | N/A | N/A |
| Staff | 133 | | | | | |
| Vaccinated | 70 | | | | | |
| Unvaccinated | 64 | | | | | |
| Staff referred to OHS | 54 | | | | | |
| Soon by OHS | 36 | 23 (64%) | 14 (36%) | 35 (97%) | 6/14 (43%) | 1 |
| No show by OHS | 18 | | | | | |
| Symptoms | 8 | 2 | 5 | 7 | 3 |

Conclusion. As evident with numerous COVID outbreaks in inpatient Psychiatry units, communicable diseases are difficult to control. Patients are in a competitive comm. setting and participating in group sessions. For better care and safety of patients and staff, our unit will screen and offer HAV vaccine to new admissions.

Disclosures. Gregory Weston, MD MSCR, Allergan (Grant/Research Support) Inessa Gendlinia, Nothing to disclose

922. The Impact of Clinically Significant CMV Infections on Other Viral Infections in the Era of Letermovir Primary Prophylaxis

Amy Spallone, MD; Krithika Srinivasan, MD; Joseph Sassa, MD; Terri Lynn Shigle, PharmD; Victoria Hardy, PharmD; Jeremy Ramdial, MD; Fareed Khawaja, MBBS; Elia Ariza Heredia, MD; Roy F Chemaly, MD, MPH, FACP, FIDSA; Baylor College of Medicine, Houston, Texas; University of Texas MD Anderson Cancer Center, Houston, Texas; The University of Texas MD Anderson Cancer Center, Houston, TX

Session: P-53. Infections in Immunocompromised Individuals

Background. Cytomegalovirus (CMV) is a frequent complication after hematopoietic cell transplant (HCT) and may increase the risk of other viral infections through its immunomodulatory effects. Letermovir, a novel antiviral targeting the viral terminase complex, was approved for primary prophylaxis in CMV-seropositive adult recipients after allogeneic HCT (allo-HCT). Because of its efficacy and safety, letermovir has become the standard of care for primary prophylaxis against CMV during the first 100 days post-transplant. However, its impact on the frequency of other viral infections and non-relapse mortality (NRM), through its reduction in clinically significant CMV infections (CS-CMVi), is not known.

Methods. This is a single-center, retrospective cohort study of 150 allo-HCT recipients, including controls that were matched by the transplant type (match-unrelated, matched-related, cord, and haploidentical), cared for at our institution between March 2016 and December 2018. Baseline demographics, transplant characteristics, prophyvax, CMV and other viral infections, and outcomes were collected (Table 1) and analyzed using IBM SPSS version 26 using a binary logistic regression model for multivariate analysis. For univariate analysis, we used Chi-square and Fischer’s Exact Test.

Results. In our 2:1 matched cohort analysis, 50 patients received letermovir for primary prophylaxis during the first 100 days post-HCT, and 100 did not. In a univariate analysis with CS-CMVi as the outcome, there was a statistically significant difference in NRM at 24 and 48 weeks. Our data indicated a trend towards a decrease in other viral infections for those without CS-CMVi (Table 2). However, in a multivariate analysis accounting for primary prophylaxis with letermovir as an effect modulator, CS-CMVi did not demonstrate a significant impact on the frequency of other viral infections but was associated with NRM at week 24 and 48 (Table 3). Interestingly, having ALL and donor CMV seropositivity were protective factors against other viral infections (Herpesviridae).

Table 1. Infections and outcomes by CS-CMV categories

| Characteristic | No CS-CMV (n = 150) | CS-CMV (n = 50) | Total (n = 200) | p-value |
|---------------|---------------------|----------------|----------------|---------|
| Age, median (range) | 55 (22-77) | 55 (22-77) | 55 (22-77) | .88 |
| Gender | Matched related | 95 (63%) | 25 (50%) | 120 (60%) | .006 |
| Race | African American | 5 (10%) | 5 (10%) | 10 (5%) | .84 |
| Ethnic | Hispanic | 48 (32%) | 24 (48%) | 72 (36%) | .34 |
| Match type | ABO matching | 48 (32%) | 24 (48%) | 72 (36%) | .34 |
| Race | Asian | 5 (10%) | 5 (10%) | 10 (5%) | .84 |
| Other | 10 (6%) | 2 (4%) | 12 (6%) | .11 |
| CKD | 30 (20%) | 10 (20%) | 40 (20%) | .70 |
| Other | 4 (2%) | 1 (2%) | 5 (2%) | .69 |

Conclusion. As evident with numerous COVID outbreaks in inpatient Psychiatry units, communicable diseases are difficult to control. Patients are in a competitive comm. setting and participating in group sessions. For better care and safety of patients and staff, our unit will screen and offer HAV vaccine to new admissions.