cause of hospitalization. Logistic regression was performed to identify risk factors for hospitalization and severe disease.

Results. A total of 393 cases were reported, including 229 (58.3%) non-hospitalized and 164 (41.7%) hospitalized infants. The most common symptoms included fever (63.4%), runny nose (45.0%), cough (35.1%) and decreased oral intake (24.9%). Significant risk factors for hospitalization included younger age and presence of comorbid conditions (excluding prematurity), as shown in the Table. Among hospitalized infants, 108 (65.9%) were admitted because of COVID-19-related illness, and 52 (31.7%) were admitted for reasons other than COVID-19. A total of 31 (7.9%) infants developed severe or critical disease. Risk factors for severe disease included prematurity and younger age (Table).

Table. Logistic regression analysis of risk factors for COVID-19 admissions and severe COVID-19.

Characteristics, n (%_row)	COVID-19 requiring admission[1]		OR (95% CI)	p-value	aOR (95% CI)[2]	p-value
	No (N = 229)	Yes (N = 108)				
Infant age[3]						
0–<1 month	13 (25.5)	38 (74.5)	3.70 (1.76–7.77)	0.001*	3.98 (1.84–8.61)	<0.001*
1–3 months	57 (55.9)	45 (44.1)	ref	---	ref	---
4–12 months	156 (86.1)	24 (13.3)	0.19 (0.11–0.35)	<0.001*	0.15 (0.08–0.29)	<0.001*
Gestational age at birth[3]						
Term (≥37 weeks)	210 (68.9)	95 (31.1)	ref	---	ref	---
Preterm (<37 weeks)	11 (50.0)	11 (50.0)	2.21 (0.93–5.28)	0.074	2.64 (0.92–7.60)	0.072
Comorbid conditions						
None/Unknown	210 (68.6)	96 (31.4)	ref	---	ref	---
≥1 comorbid condition	19 (61.3)	12 (38.7)	1.38 (0.64–2.96)	0.406	4.13 (1.66–10.29)	0.002*
Phase of COVID-19 pandemic						
1st wave (April–August 2020)	47 (72.3)	18 (27.7)	ref	---	ref	---
2nd wave (September 2020–February 2021)	127 (63.8)	72 (36.2)	1.48 (0.80–2.74)	0.212	1.63 (0.79–3.35)	0.184
3rd wave (March–May 2021)	55 (75.3)	18 (24.7)	0.85 (0.40–1.83)	0.685	1.11 (0.45–2.73)	0.815

Characteristics, n (%_row)	Disease Category[4]		OR (95% CI)	p-value	aOR (95% CI)[2]	p-value
	Non-severe COVID-19 (N = 306)	Severe COVID-19 (N = 31)				
Infant age[3]						
0–<1 month	39 (76.5)	12 (23.5)	2.55 (1.03–6.26)	0.042*	---	---
1–3 months	91 (89.2)	11 (10.8)	ref	---	---	---
4–12 months	172 (95.6)	8 (4.4)	0.38 (0.15–0.99)	0.048*	---	---
Gestational age at birth[3]						
Term (≥37 weeks)	280 (91.8)	25 (8.2)	ref	---	---	---
Preterm (<37 weeks)	16 (72.7)	6 (27.3)	4.20 (1.51–11.69)	0.006*	---	---
Comorbid conditions						
None/Unknown	280 (91.5)	26 (8.5)	ref	---	---	---
≥1 comorbid condition	26 (83.9)	5 (16.1)	2.07 (0.73–5.85)	0.169	---	---
Phase of COVID-19 pandemic						
1st wave (April–August 2020)	60 (92.3)	5 (7.7)	ref	---	---	---
2nd wave (September 2020–February 2021)	176 (88.4)	23 (11.6)	1.57 (0.57–4.31)	0.383	---	---
3rd wave (March–May 2021)	70 (95.9)	<5 (<7.7)	0.51 (0.18–2.24)	0.376	---	---

aOR = Adjusted odds ratio; OR = Odds ratio. Asterisks (*) denote p<0.05.
[1]Excludes 52 patients admitted for reasons other than COVID-19 and four patients with reason for admission not assigned due to incomplete reports.
[2]Multivariable analysis of COVID-19 admissions conducted among 323 patients. Analysis of severe COVID-19 not conducted due to the small number of infants with severe disease.
[3]Age category not determined for 4 infants (3 outpatients and 1 inpatient; Age category not available for 4 COVID-19 admissions; Gestational age category not available for 4 infants (2 outpatients and 2 COVID-19 admissions; 4 non-severe COVD-19).
[4]Disease category was defined using the Dong criteria. Non-severe COVID-19 included mild disease (symptoms present, but without respiratory distress, or any abnormal radiological findings) and moderate disease (patients who experienced lower respiratory disease or hematologic abnormalities and had abnormal radiologic findings, but lacked other organ involvement and the need for respiratory support). Severe COVID-19 included severe disease (patients who experienced respiratory distress and/or requiring supplemental oxygen) and critical disease (patients admitted to intensive care unit (ICU) or requiring ventilation and/or experienced clinical features of shock or other organ involvement).

Conclusion. We describe one of the largest cohort of infants with SARS-CoV-2 infection. Severe disease in this age group is uncommon, with younger age and prematurity being significant risk factors for severe COVID-19.

484. Identification of Early Features to Differentiate Hospitalized Children Admitted for Suspected MIS-C from Alternative Diagnoses

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Session: P-23. COVID-19 Special populations (e.g. pregnant women, children, immunocompromised, etc)

Background. Multi-system inflammatory syndrome in children (MIS-C) is a rare consequence of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). MIS-C shares features with common infectious and inflammatory syndromes and differentiation early in the course is difficult. Identification of early features specific to MIS-C may lead to faster diagnosis and treatment. We aimed to determine clinical, laboratory, and cardiac features distinguishing MIS-C patients within the first 24 hours of admission to the hospital from those who present with similar features but ultimately diagnosed with an alternative etiology.

Methods. We performed retrospective chart reviews of children (0-20 years) who were admitted to Vanderbilt Children's Hospital and evaluated under our institutional MIS-C algorithm between June 10, 2020-April 8, 2021. Subjects were identified by review of infectious disease (ID) consults during the study period as all children with possible MIS-C require an ID consult per our institutional algorithm. Clinical, lab, and cardiac characteristics were compared between children with and without MIS-C. The diagnosis of MIS-C was determined by the treating team and available consultants.

P-values were calculated using two-sample t-tests allowing unequal variances for continuous and Pearson's chi-squared test for categorical variables, alpha set at < 0.05.

Results. There were 128 children admitted with concern for MIS-C. Of these, 45 (35.2%) were diagnosed with MIS-C and 83 (64.8%) were not. Patients with MIS-C had significantly higher rates of SARS-CoV-2 exposure, hypotension, conjunctival injection, abdominal pain, and abnormal cardiac exam (Table 1). Laboratory evaluation showed that patients with MIS-C had lower platelet count, lymphocyte count and sodium level, with higher c-reactive protein, fibrinogen, B-type natriuretic peptide, and neutrophil percentage (Table 2). Patients with MIS-C also had lower ejection fraction and were more likely to have abnormal electrocardiogram.

Table 1. Demographic and Clinical Signs and Symptoms of Children with and without MIS-C

Characteristic	All Children (n=128)	MIS-C (n=45)	Non-MIS-C (n=83)	P-value
Age, years—mean (SD)	9.2 (5.6)	9.6 (4.3)	9.0 (6.2)	0.605
Sex, male—no. (%)	76 (59.4)	26 (57.8)	50 (60.2)	0.786
Race—no. (%)				
White	90 (70.3)	29 (64.4)	61 (73.5)	0.504
Black	15 (11.7)	7 (15.6)	8 (9.6)	
Other	23 (18.0)	9 (20.0)	14 (16.9)	
Ethnicity—no. (%)				
Hispanic/Latino	16 (12.5)	6 (13.3)	10 (12.1)	0.917
Weight (kg)—mean (SD)	39.5 (28.9)	42.1 (29.1)	38.1 (28.8)	0.448
Height (cm)—mean (SD)	132.2 (33.7)[a]	137.2 (24.4)	129.4 (37.7)[b]	0.212
Body mass index—mean (SD)	19.8 (6.7)[a]	20.2 (7.5)	19.6 (6.3)[b]	0.613
Past medical history—no. (%)				
Asthma/reactive airway disease	12 (9.4)	2 (4.4)	10 (12.1)	0.159
SARS-CoV-2 exposure/disease history—no. (%)	55 (43.0)	32 (71.1)	23 (27.7)	<0.001
Vital Signs—no. (%)				
Fever	123 (96.1)	45 (100)	78 (94.0)	0.093
Fever duration, days—mean (SD)	5.9 (5.4)	5.2 (1.9)	6.3 (6.7)	0.261
Maximum temperature, Fahrenheit—mean (SD)	103.1 (1.5)[e]	103.3 (1.2)[f]	103.0 (1.6)[g]	0.312
Hypotension	52 (40.6)	35 (77.8)	17 (20.5)	<0.001
Mucocutaneous and lymphatic signs/symptoms—no. (%)				
Sore throat	32 (25.2)[h]	10 (22.7)[i]	22 (26.5)	0.641
Bilateral conjunctival injection	53 (41.7)[h]	24 (54.6)[j]	29 (34.9)	0.033
Oral mucosal changes	48 (38.1)[h]	16 (37.2)[j]	32 (38.6)	0.883
Unilateral cervical adenopathy (>1.5 cm)	4 (3.2)[a]	1 (2.3)[j]	3 (3.6)	0.696
Hepatomegaly/Splenomegaly	4 (3.2)[a]	0 (0)[j]	4 (4.8)	0.143
Rash (any)	71 (55.5)	30 (66.7)	41 (49.4)	0.061
Cardiac signs—no. (%)				
Abnormal cardiac exam	47 (36.7)	22 (48.9)	25 (30.1)	0.035
Heart rate—mean (SD)	119.8 (27.3)[k]	125.2 (22.4)	116.3 (29.7)[l]	0.090
PR interval—mean (SD)	134.3 (29.8)[e]	139.2 (38.7)[i]	131.1 (22.1)[l]	0.162
PR/HR ratio—mean (SD)	1.2 (0.5)[e]	1.2 (0.4)[i]	1.2 (0.5)[l]	0.474
Respiratory signs/symptoms—no. (%)				
Cough	41 (32.0)	14 (31.1)	27 (32.5)	0.870
Dyspnea	21 (16.4)	7 (15.6)	14 (16.9)	0.848
Abnormal respiratory exam	18 (14.4)[a]	7 (15.6)	11 (13.8)[b]	0.450
Gastrointestinal signs/symptoms—no. (%)				
Diarrhea	53 (41.4)	24 (53.3)	29 (34.9)	0.189
Abdominal Pain	67 (52.3)	33 (73.3)	34 (41.0)	0.006
Nausea	51 (39.8)	23 (51.1)	28 (33.7)	0.169
Vomiting	69 (53.9)	27 (60.0)	42 (50.6)	0.415
Abnormal abdominal exam	38 (29.7)	18 (40.0)	20 (24.1)	0.114
Acute abdomen	3 (2.3)	2 (4.4)	1 (1.2)	0.175
Hematochezia	1 (0.8)	0 (0)	1 (1.2)	0.695
Neurological symptoms—no. (%)				
Headache	67 (52.8)[h]	29 (64.4)	38 (45.3)[m]	0.051
Neck pain	19 (15.1)[a]	8 (17.8)	11 (13.6)[b]	0.528
Musculoskeletal signs/symptoms—no. (%)				
Edema of hands/feet	20 (15.8)[h]	6 (13.3)	14 (17.1)[m]	0.580
Arthritis	5 (3.9)[h]	1 (2.2)	4 (4.9)[m]	0.462
Arthralgia	18 (14.2)[h]	5 (11.1)	13 (15.9)[m]	0.464
Myalgia	39 (30.5)	20 (44.4)	19 (22.9)	0.011

Abbreviations: MIS-C, multisystem inflammatory syndrome in children; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2; SD: standard deviation. P-values were calculated using two-sample t-tests allowing unequal variances for continuous and Pearson c² test for categorical variables, alpha set at <0.05. [a]n=126; [b]n=81; [e]n=119; [h]n=74; [i]n=113; [j]n=40; [k]n=73; [l]n=127; [m]n=44; [a]n=43; [h]n=114; [m]n=69; [m]n=82

Table 2. Laboratory and Cardiac Characteristics of Children with and without MIS-C

Laboratory Value—mean (SD)	All Children (n=128)	MIS-C (n=45)	Non-MIS-C (n=83)	P-value
White blood count, x10³/μL	11.5 (7.1)	10.4 (5.4)	12.1 (7.9)	0.195
Hemoglobin, g/dL	11.5 (1.8)	11.9 (1.2)	11.3 (2.1)	0.107
Platelets, x10³/μL	260.6 (146.2)	186.7 (63.3)	300.6 (162.3)	<0.001
Neutrophils %	71.4 (17.9)[a]	82.1 (7.0)[b]	65.5 (19.3)[c]	<0.001
Absolute neutrophils, x10³/μL	8.4 (5.8)	8.7 (4.6)	8.3 (6.4)	0.682
Absolute lymphocytes, x10³/μL	1.9 (2.0)	0.98 (0.6)	2.4 (2.2)	<0.001
Neutrophil/lymphocyte ratio	9.1 (13.3)[a]	10.9 (6.9)[b]	8.1 (15.8)[c]	0.280
Sodium, mmol/L	134.5 (3.6)	132.8 (2.9)	135.5 (3.7)	<0.001
Blood urea nitrogen, mmol/L	14.9 (11.4)[d]	16.4 (11.1)	14.0 (11.6)[e]	0.255
Creatinine, mg/dL	0.9 (1.2)	0.9 (0.9)	0.9 (1.3)	0.862
BUN/creatinine ratio	18.7 (8.3)[d]	19.9 (7.7)	18.0 (8.5)[e]	0.212
Albumin, g/dL	3.5 (0.5)[d]	3.4 (0.5)	3.6 (0.5)[e]	0.102
AST, unit/L	62.4 (106.3)[d]	45.6 (23.7)	71.6 (130.5)[e]	0.180
ALT, unit/L	50.0 (95.4)[d]	35.7 (24.9)	57.9 (116.9)[e]	0.212
Lactate dehydrogenase, unit/L	432.5 (226.8)[f]	384.3 (125.0)[b]	472.2 (279.8)[g]	0.063
C-reactive protein, mg/L	135.4 (103.7)[d]	190.5 (98.4)	105.2 (94.2)[e]	<0.001
Erythrocyte sedimentation rate, mm/hr	48.1 (30.9)[i]	49.5 (23.0)[j]	47.2 (34.8)[k]	0.697
Troponin, ng/mL	0.6 (3.3)[a]	0.8 (4.0)	0.5 (2.7)[g]	0.621
B-type natriuretic peptide, pg/mL	270.5 (640.1)[l]	452.1 (778.4)	159.5 (513.5)[m]	0.016
Ferritin, ng/mL	729.3 (1484.4)[n]	637.2 (447.5)[p]	799.5 (1936.9)[p]	0.596
Fibrinogen, mg/dL	504.9 (161.6)[d]	568.7 (147.1)[j]	448.0 (153.7)[g]	<0.001
Neutrophils with vacuolization/toxic granulation—no. (%)	33 (25.8)	18 (40.0)	15 (18.1)	0.007
Electrocardiogram abnormal—no. (%)	47 (43.1)[v]	23 (56.1)[w]	24 (35.3)[x]	0.034
Echocardiogram—mean (SD)				
Left ventricle ejection fraction—no.%	57.1 (10.6)[y]	52.9 (9.1)[z]	60.1 (10.7)[aa]	<0.001
Coronary artery ectasia—no. (%)				
Right main coronary artery	7 (8.3)[bb]	0 (0)	7 (14.9)[jj]	0.014
Left main coronary artery	2 (2.2)[cc]	0 (0)	2 (3.9)[dd]	0.210
Left anterior	6 (8.7)[j]	0 (0)	6 (14.3)[qm]	0.040
Coronary z score—mean (SD)				
Right main coronary artery	1.2 (3.1)[h]	0.7 (0.8)[ym]	1.6 (4.0)[qm]	0.410
Left main coronary artery	0.09 (1.0)[hj]	-0.1 (0.9)	0.2 (1.0)[rr]	0.297
Left anterior	1.2 (3.3)[w]	0.2 (1.0)[hi]	1.7 (3.9)[rr]	0.166

Abbreviations: ALT, alanine aminotransferase; AST, aspartate aminotransferase; BUN, blood urea nitrogen, SD: standard deviation.
P-values were calculated using two-sample t-tests allowing unequal variances for continuous and Pearson χ² test for categorical variables, alpha set at <0.05.; [a]n=124; [b]n=44; [c]n=80; [d]n=127; [e]n=82; [f]n=93; [g]n=42; [b]n=51; [j]n=119; [i]n=81; [k]n=118; [l]n=116; [m]n=72; [n]n=97; [a]n=55; [p]n=92; [q]n=38; [r]n=54; [s]n=87; [t]n=41; [u]n=46; [v]n=109; [w]n=41; [x]n=68; [y]n=95; [z]n=40; [aa]n=55; [m]n=92; [bb]n=52; [mm]n=42; [m]n=30; [m]n=57; [m]n=33; [q]n=14; [m]n=27

Conclusion. We identified early features that differed between patients with MIS-C from those without. Development of a diagnostic prediction model based on these early distinguishing features is currently in progress.

485. Pediatrics Institutional COVID-19 Review

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Session: P-23. COVID-19 Special populations (e.g. pregnant women, children, immunocompromised, etc)

Background. Coronavirus disease (COVID-19) caused by SARS-COV2 represents global public health concern, with varied severity of illness in different ages and racial groups. This study aims to describe clinical presentation and outcomes in children aged 0-21 years in a community hospital setting in New Jersey.

Methods. This is a retrospective medical record review of pediatric patients (0-21 years) admitted to Saint Barnabas Medical Center between March 2020-December 2020 with confirmed diagnosis of COVID-19 infection. Diagnosis of COVID-19 infection is based on ICD-10 diagnosis code. Data was extracted from electronic medical records, including demographics, pre-existing conditions, presenting symptoms, treatments used and outcomes.

Results. We identified 48 cases of pediatric COVID-19 patients at Saint Barnabas Medical Center during period of 03/20-12/20. Review of demographic data showed 29 patients (60%) were female, and 19 (40%) were male. Race distribution was 38% black, 17% white, 4 % Asian Indian, and 41% others/unknown. Age distribution was as follows: 40% >15 yrs, 15% 11-15 yrs, 15% 0-1 yrs, 13% 6-10 yrs, 13% 1-5 yrs, and 6% newborn. Fever (65%) was the most frequent symptom identified, followed by cough (31%), nausea/vomiting (29%), abdominal pain (19%), shortness of breath (17%), rash (15%), diarrhea (10%), headache (10%), myalgia/body-aches (8%), chest pain (6%), red eyes (6%), and loss of taste/smell (2%). Of 48 patients, 10 (21%) had positive chest X-ray findings of lung infiltrates or opacities, 4 (8%) had abnormal echocardiogram findings, and 1 (2%) had abnormal CT chest. 21 of 48 patients had underlying comorbid conditions, with Diabetes and Asthma being the most common. No deaths were reported. 8 of 48 COVID-19 patients were diagnosed with MIS-C. Of these MIS-C patients, 5 (63%) were male and 3 (38%) were female. 6 of 8 affected patients were black (75%). 50% of MIS-C patients were between 6-10 years. 3 of 8 patients (38%) had abnormal echocardiogram findings.

Conclusion. This review supports clinical findings from other studies and also suggests certain racial ethnicities may be disproportionately impacted, which warrants further exploration to determine genetics vs environmental factors that lead to increased predisposition to severe illness.

Disclosures. **All Authors**: No reported disclosures

486. Characteristics Associated with SARS-CoV-2 Infection in Children

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Session: P-23. COVID-19 Special populations (e.g. pregnant women, children, immunocompromised, etc)

Background. We sought to describe the range of Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) infection in children.

Methods. Patients < 18 years of age who had a positive nasopharyngeal polymerase chain reaction (PCR) for SARS-CoV-2 at a single health system in central Pennsylvania from 3/19/2020-12/31/2020 were identified. Using a random number generator, 150 additional patients < 18 years of age who had a negative PCR test were also identified. Asymptomatic patients and those without clinical data in the electronic medical record were excluded from analysis. Demographic characteristics, symptoms present at the time of testing, and outcomes were compared between PCR-positive and negative patients. Odds ratios were calculated using univariable and multivariable logistic regression models to patients with positive vs. negative PCR tests.

Results. We included 544 patients in analysis, 412 (76%) of which had a positive SARS-CoV-2 PCR. PCR-positive patients were statistically more likely to have a known contact, no comorbidities, and to present with cough, cold-like symptoms, headache, or loss of taste and smell. All patients who presented with loss of taste and smell were PCR positive at time of presentation. Positive patients were statistically less likely to present with fever or emesis than negative patients. Multivariable regression identified increased age, cough, cold symptoms, headache, and non-white race as predictive of PCR positivity. Patients who tested positive were statistically less likely to be admitted to the hospital and less likely to require respiratory support than negative patients.

Conclusion. Loss of taste and smell is a specific, though uncommon, indicator of SARS-CoV-2 infection in the pediatric population. Headache, cough, and cold-like symptoms are also suggestive of SARS-CoV-2 infection, while fever and gastrointestinal symptoms appear less common. This data suggests that screening questions developed for adults may be less applicable in children. Future research, including more dedicated and prospective studies, is warranted to identify patients in whom a positive SARS-CoV-2 test is sufficiently likely to warrant isolation and testing.

Disclosures. **All Authors**: No reported disclosures

487. Experience with Remdesivir for Treatment of SARS-CoV-2 in Patients with Liver Cirrhosis

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Session: P-23. COVID-19 Special populations (e.g. pregnant women, children, immunocompromised, etc)

Background. Remdesivir is a nucleotide analogue antiviral that was FDA approved for the treatment of hospitalized patients with coronavirus disease 2019 (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS CoV-2). Remdesivir has been associated with elevations in serum aminotransferase levels but most cases being mild to moderate and reversible upon discontinuation. Although national COVID-19 guidelines and the American Association for the Study of Liver Diseases (AASLD) currently recommend remdesivir for use in hospitalized patients requiring supplemental oxygen, data is limited using remdesivir in patients with chronic liver disease. Here, we describe our experience with remdesivir in patients with liver cirrhosis.

Methods. Patients with liver cirrhosis who received remdesivir were identified either prospectively or retrospectively by primary or secondary ICD-10 codes indicating liver disease. Data collected included patient demographics, underlying cause of cirrhosis, co-morbidities, Child-Pugh score, laboratory values (serum aminotransferase levels, serum creatinine) during and following remdesivir, adverse reactions attributed to remdesivir, and mortality (in-hospital, 30-day, and 90-day).

Results. A total of 4 patients with underlying liver cirrhosis completed a 5-day course of remdesivir treatment. On admission, Child-Pugh class was A for 1 patient, B for 2 patients, and C for 1 patient. Causes for cirrhosis were nonalcoholic steatohepatitis (NASH), hepatic amyloidosis, and chronic hepatitis B. There were no acute elevations in aminotransferase levels or adverse events attributed to remdesivir therapy. Mortality was high with 50% in-hospital mortality. Of the 2 other patients who survived to discharge, one was discharged to home hospice and the other was readmitted within 30 days and expired during that admission.

Conclusion. Since there is limited data available using remdesivir in patients with advanced liver disease, we did not identify any safety concerns related to remdesivir in our cirrhotic patients. Mortality was high illustrating the poor outcomes of patients with advanced liver disease and COVID-19. Patients with cirrhosis should be offered remdesivir if clinically appropriate.

Disclosures. **All Authors**: No reported disclosures

488. Comparison of Demographics and Clinical Characteristics of Multisystem Inflammatory Syndrome in Children and Kawasaki Disease

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Session: P-23. COVID-19 Special populations (e.g. pregnant women, children, immunocompromised, etc)

Background. Multisystem inflammatory syndrome in children (MIS-C) is an illness associated with recent SARS-CoV-2 infection or exposure. Kawasaki disease (KD), a vasculitis with an unknown etiology, has overlapping clinical presentation with MIS-C, making it difficult to clinicians for distinguish between them. Therefore, we aimed to compare demographic, laboratory, and clinical characteristics between MIS-C and KD in hospitalized children in Nashville, TN.

Methods. We conducted a single-center retrospective chart review for hospitalized children under 18 years who met American Heart Association criteria for KD and were treated with intravenous immunoglobulin from May 2000 to December 2019, and children meeting the CDC criteria for MIS-C from July 2020 to May 2021. Data abstraction for patients' demographics, clinical presentation, laboratory values and imaging results was performed. Pearson's chi-squared test for categorical variables and Wilcoxon rank sum test for continuous variables, with alpha=5%, were used to compare groups.

Results. A total of 603 KD and 52 MIS-C hospitalized patients were included. Children with MIS-C were older than those with KD. A higher frequency of male sex was noted in both groups, with no significant differences in race and ethnicity (Table). MIS-C children frequently presented with symptoms similar to KD (63.5% rash, 55.8% conjunctivitis, 28.9% mucous membrane changes); however, only one MIS-C patient met criteria for complete KD (Figure). Both MIS-C and KD children presented with elevated CRP and ESR, but the median value of CRP in MIS-C children was significantly higher (Table). In addition, white cell count was lower in MIS-C children, which is primarily driven by the lower absolute lymphocyte count in this group (0.9 vs 2.7, p< 0.001), and echocardiography was more likely to be abnormal at presentation compared to KD (Table).