Figure 1: Prevalence of seronegative samples to measles analyzed according to HIV status and age group (n=2663)

	% NEG	% NEG+IND
HIV+ (n=348)	28.16	40.8
HIV- (n=2663)	22.9	33.2
p	**0.031**	**0.005**
HIV+ <40 years	32.5	45.3
HIV+ >40 years	14.5	31.3
p	**0.002**	**0.02**
HIV- <40 years	26.4	38.3
HIV- >40 years	14.0	20.2
p	**<0.001**	**0.001**

NEG: Negative IND: Indeterminate

NOTE: The method to determine antibodies to measles include an "indeterminate" or "grey" zone of values (**VIDAS®** Measles IgG, Biomeriex)

Figure 2: Proportion of seronegativity to measles according to age and HIV status

HIV status	Age group	N, total	N, negative	N, neg + ind	% neg	% neg + ind
POSITIVE	50-60	12	0	1	0%	**8%**
	40-49	71	12	25	7%	**35%**
	30-39	169	56	74	33%	**44%**
	18-29	96	30	46	31%	**48%**
NEGATIVE	50-60	270	13	20	5%	**7%**
	40-49	380	78	111	21%	**29%**
	30-39	1115	303	438	27%	**39%**
	18-29	550	132	200	24%	**36%**

Neg: Negative Ind: Indeterminate %: Percentage

Disclosures. **E. Bissio**, MSD: Employee, Salary. **M. E. Perez Carrega**, MSD: Employee, Salary. **J. L. Montes**, MSD: Employee, Salary.

1901. Safety, Tolerability, and Efficacy of Fluoxetine as an Antiviral for Enterovirus D68 Associated Acute Flaccid Myelitis: A Retrospective Multicenter Cohort Study

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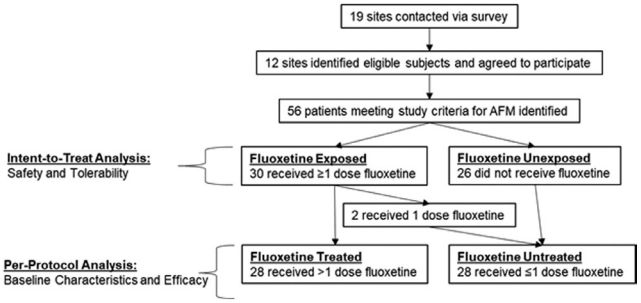
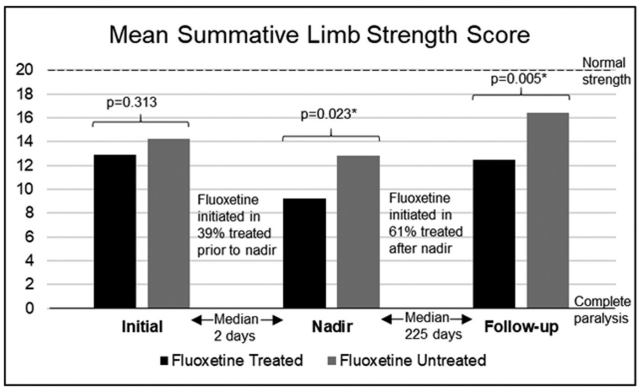
Background. Most patients with enterovirus (EV) D68-associated acute flaccid myelitis (AFM) have long-term disability. No effective therapies have been identified. Fluoxetine is the only FDA-approved medication with *in vitro* antiviral activity against EV-D68. This study retrospectively analyzed the safety, tolerability, and efficacy of fluoxetine for EV-D68-associated AFM.

Methods. A multicenter cohort study of US children with AFM in 2015–2016 compared serious adverse events (SAEs), adverse effects, and outcomes between fluoxetine-treated patients and untreated controls with AFM. Fluoxetine was administered at the discretion of treating providers with data gathered retrospectively. The primary outcome was summative limb strength score (SLSS; sum of Medical Research Council strength in all four limbs).

Results. 56 patients with AFM from 12 centers met study criteria (Figure 1). Among 30 patients exposed to fluoxetine, no SAEs were reported and adverse effects were similar to controls ($P = 0.16$). The 28 patients treated with >1 dose of fluoxetine were more likely to have EV-D68 identified (57.1% vs. 14.3%, $P = 0.001$). Fluoxetine-treated patients had similar strength on initial examination compared with untreated controls (mean SLSS 12.9 vs. 14.3, $P = 0.313$), but more severe paralysis at nadir (mean SLSS 9.25 vs. 12.82, $P = 0.023$) and latest follow-up (mean SLSS 12.5 vs. 16.4, $P = 0.005$) (Figure 2). In propensity-adjusted analysis, SLSS from initial examination to latest follow-up decreased by 0.2 (95% CI: −1.8 to +1.4) in fluoxetine-treated patients and increased by 2.5 (95% CI: +0.7 to +4.4) in controls ($P = 0.015$).

Conclusion. Fluoxetine was safely administered and relatively well-tolerated. Patients with AFM treated with fluoxetine were more likely to have EV-D68-associated disease and had more severe paralysis at nadir and poorer long-term outcomes. These data do not suggest a positive efficacy signal for fluoxetine as a potential antiviral therapy for AFM.





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

1902. A Survey of Pediatric Bone Marrow Transplant Centers Regarding Local Cytomegalovirus Prophylaxis Management Practices and Interest in a Future Randomized Trial

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Background. Cytomegalovirus (CMV) is a major source of morbidity and mortality after hematopoietic cell transplantation (HCT). A recent adult trial comparing letermovir to placebo, found this agent to be efficacious in preventing CMV reactivation with limited toxicity. Additional investigation of letermovir in pediatric HCT recipients is needed. To inform the feasibility of a pediatric trial, we surveyed bone marrow transplant (BMT) centers registered with the Children's Oncology Group (COG) regarding their CMV management practices and interest in a pediatric trial for CMV prevention.

Methods. A brief 6-item questionnaire was created using REDCap™ and distributed by email to all COG-approved BMT Centers. The initial email request was sent on March 26, 2018 to the BMT physician representative listed in the COG member roster. A follow-up request was sent on April 2, 2018. The questionnaire requested information about CMV prophylaxis strategies, including antiviral agent(s) employed, and interest in a pediatric trial of CMV prophylaxis.

Results. The questionnaire was emailed to 89 BMT centers and was completed at 57 (64%). Of these, 23 (40%) reported giving prophylaxis to all or a subset of allogeneic/haploidentical HCT recipients. The most common indication for CMV prophylaxis (21/23)