Conclusion: There is a wide spectrum of illness in children with SARS-CoV-2, ranging from asymptomatic to critical illness. Hispanic ethnicity was disproportionately represented in our cohort, which requires further evaluation. We found that young age, comorbid conditions, and CRP appear to be risk factors for severe disease in children.

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82. Multisystem Inflammatory Syndrome in Children and non-sars-cov-2 Infections: A Retrospective Cross-sectional Study

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Session: O-15. COVID-19 What to be Aware of: Special and Vulnerable Populations

Background: Multisystem inflammatory syndrome in children (MIS-C) has been described in areas with high Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2) burden. Clinical features included in the MIS-C case definition (e.g fever, elevated inflammatory markers) overlap with features of other childhood infections. The prevalence of non-SARS-CoV-2 infection in patients evaluated for MIS-C has not been described.

Patients evaluated for MIS-C, and therapies administered.

Number	Total evaluated	MIS-C alone	Infection + MIS-C	Bacterial infection alone	Viral infection alone
Number	39	16	2	4	1
Immunomodulation/Antiplatelet					
Anakinra	4	3	1	0	0
Aspirin	14	10	1	3	0
IVIg	17	12	2	3	0
Methylprednisolone	14	12	1	1	0
Antibiotics					
Antibacterials	21	11	2	4	0
Antivirals	5	3	2	0	0
Types of infections			2		• Human metapneumovirus
			• *Escherichia coli* UTI plus herpes stomatitis (1)	• Staphylococcal toxic shock syndrome (1)	
			• *Pseudomonas aeruginosa* bacterial tracheitis plus *Enterococcus faecalis* UTI (1)	• *Staphylococcus aureus* lymphadenitis (2)	
				• Polymicrobial labial abscess (1)	

Abbreviations: MIS-C = Multisystem inflammatory syndrome in children (MIS-C); UTI = urinary tract infection

Methods: Retrospective cohort study of patients < 21 years of age admitted to a freestanding children's hospital in Boston, MA from May 14-June 6, 2020 who were evaluated for MIS-C. We identified patients undergoing Rheumatology consultation and echocardiogram (per the hospital's protocol for evaluating children with suspicion for MIS-C). We tabulated patients evaluated for MIS-C found to have non-SARS-CoV-2 infection detected on standard microbiologic testing.

Results: 39 patients met inclusion criteria. Median age was 5 years (IQR 2–12 years). Of evaluated patients, 19/39 (49%) were diagnosed with MIS-C according to the Massachusetts Department of Public Health case definition; 10/39 (26%) required ICU admission. Non-SARS-CoV-2 infections were identified in 7/39 (18%), of whom 5/7 (71%) had bacterial infections, 1/7 (14%) had viral infection, and 1/7 (14%) had viral and bacterial co-infections; no fungal or parasitic infections were identified. Of patients diagnosed with MIS-C, 2/19 (11%) were found to have non-SARS-CoV-2 infection. Additionally, 5/19 (26%) had a positive polymerase chain reaction test for SARS-CoV-2 at time of MIS-C diagnosis, of whom 4/5 (80%) received remdesivir. Of patients evaluated for MIS-C, 17/39 (44%) received intravenous immune globulin, 14/39 (36%) aspirin, 4/39 (10%) anakinra, and 14/39 (36%) methylprednisolone. Additionally, 21/39 (54%) received antibacterial and 5/39 (13%) antiviral therapy (Table).

Conclusion: In this study, non-SARS-CoV-2 infections were diagnosed in 18% of children evaluated for MIS-C. Clinicians should consider alternative or concomitant infectious diagnoses in patients undergoing MIS-C evaluation. Research is needed to identify clinical and laboratory features that may distinguish patients with MIS-C from those with non-SARS-CoV-2 infection.

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83. A Descriptive Analysis of a Multi-disciplinary Approach to Opioid Use Disorder Treatment Within an Infectious Diseases Clinic

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Session: O-16. Current Issues in Public Health

Background: Opioid overdose is the leading cause of injury-related death in the US. Kentucky ranks in the top 5 states for opioid overdose deaths. The rate of injection drug use-associated infections (IDU-AI) has risen; the University of Kentucky Infectious Diseases division (UKID) treated 401 endocarditis cases in 2018, of which 73% were IDU-AI. To curb overdose deaths, ease financial burden on healthcare, and improve patient outcomes, patients need tools for recovery from opioid use disorder (OUD). Access to OUD treatment in Kentucky and much of the US is limited. Poverty, unemployment, and legal issues are barriers.

Methods: UKID implemented a multi-disciplinary approach to expand access to medication assisted treatment (MAT). This is an ongoing study. Any patient ≥18 years old with IDU-AI and OUD is eligible for enrollment unless pregnant or incarcerated. At enrollment and at three additional time points, patients complete both a study specific and Government Performance and Results Act (GPRA) survey. Patients may start MAT and mental health counseling with UKID or be referred elsewhere and are eligible for transportation assistance and medical case management.

Results: To date, there have been 127 referrals. Of these, 87 (69%) were eligible and 54 enrolled (62% of eligible). Primary IVDU-AI includes HIV (n=4; 7%), HCV (n=5; 9%), HIV/HCV (n=3; 6%), endocarditis (n=32; 59%), and other (n=10; 19%).

Patients are 48% male (n=26) and 91% white (n=91) with a median age of 34 years (IQR: 16); 35% are receiving MAT (n=19) with 14.8% (n=8) managed by UKID. Other service data are available for 51 patients. Naloxone was dispensed to 45 (88%) patients, 24 (47%) received relapse prevention services, 13 (25%) engaged in peer support, 9 (18%) participated in self-help groups, and 10 (20%) received transportation aid.

Conclusion: Increasing engagement in MAT and wrap-around services is an important touchpoint for OUD. We present a comprehensive program to achieve this for patients who would otherwise be discharged without follow-up for OUD. This program shows proof of concept that patients can be engaged in MAT by ID providers. Ongoing analysis will include longitudinal review of patient progress and outcomes, including hospital readmission, and a study to determine patients' perceived impact on their quality of life.

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84. Clarifying the Congenital Zika Syndrome Phenotype and Expanding to Congenital Zika Spectrum in the Absence of Laboratory Evidence

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Session: O-16. Current Issues in Public Health

Background: Congenital Zika syndrome (CZS) is a term used to describe the pattern of anomalies in infants due to congenital Zika virus (ZIKV) infection. To date, published reports of infants with these anomalies have been primarily small case series of the most severely affected infants and attempts to determine the CZS phenotype have been based on those reports. Lack of a standard definition has led to inconsistencies in the term's use in the literature and uncertainty about the full spectrum of anomalies, limiting the application for diagnostic and surveillance purposes.

Cluster analysis of brain and eye anomalies associated with congenital Zika infection. Clustering occurred independent of laboratory evidence of Zika virus infection, yielding a clinically distinct phenotype associated with congenital infection.
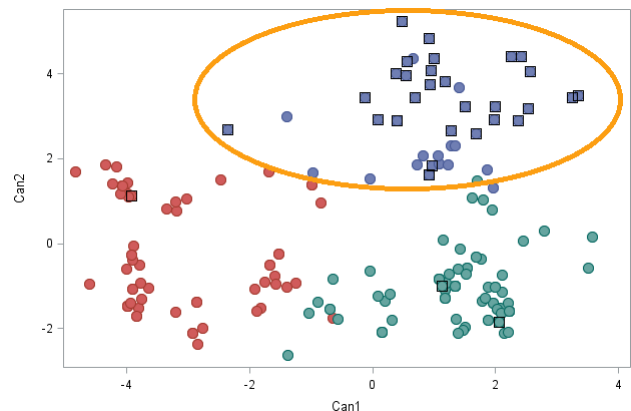
Methods: We sought to understand which defects co-occur with possible congenital ZIKV infection using data from 415 mother-infant dyads with laboratory evidence of confirmed or presumptive Zika virus infection from the U.S. Zika Pregnancy and Infant Registry, and a comparison group of 4534 mother-infant dyads with no documented or plausible ZIKV infection from the Zika Birth Defects Surveillance System. We use k-means cluster analysis, discriminant analysis, and regression approaches to identify combinations of defects consistent with possible congenital ZIKV infection.

Results: A clinically distinct phenotype emerged as a single cluster in infants for whom both brain and eye defects were recorded that corresponded to evidence of confirmed or probable ZIKV infection. A combination of six defects (sub-cortical calcifications, chorioretinal atrophy/pigmentary anomalies, arthrogryposis or clubfoot, cerebral atrophy or ventriculomegaly, abnormal cortical gyration, and optic nerve atrophy/pallor/other optic nerve abnormalities) predicted the presence of laboratory evidence (area under the receiver operating characteristics curve: 0.95, 95% confidence interval: 0.90–0.99).

Conclusion: Further analyses are underway to develop a scoring rubric to weigh evidence of specific congenital anomalies, separately and in combination, that are consistent with laboratory evidence of congenital ZIKV infection. A quantitatively determined spectrum of Zika-associated anomalies, based on the presence of specific combinations of congenital anomalies, will inform a clinical decision tool to improve patient counseling and public health surveillance practices.

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85. Characterization of Group B *streptococcus* Strains with Reduced Susceptibility to Beta-lactam Antibiotics, Active Bacterial Core Surveillance, 1998–2017

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