

**2191. Hepatitis A Outbreak in Southeast Michigan: No Longer a Third World Disease**

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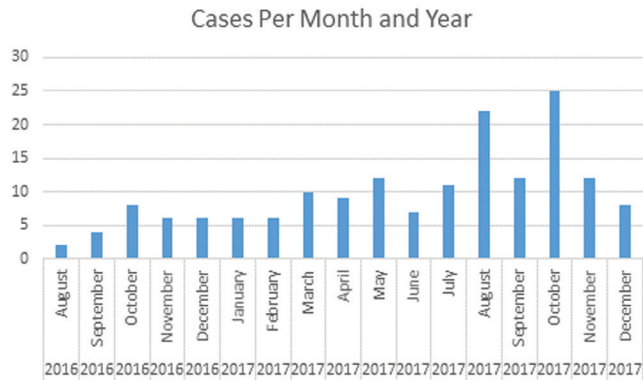
**Background.** Hepatitis A (Hep A) is a self-limiting diarrheal illness occurring in underdeveloped countries. August 2016 marked the onset of an outbreak in Southeast Michigan. Our study characterizes the presentation and clinical course of Hep A patients that presented to our healthcare system.

**Methods.** This study included all Hep A positive cases that presented to Henry Ford Health System from August 2016 to December 2017. Electronic medical records were reviewed for demographics, sexual history, travel history, food exposure, illicit drug use, signs, symptoms and outcomes. Data were also collected on healthcare units of presentation, screening, and care including emergency department, clinic, inpatient hospitalization, or transfer from another facility. Outcomes included hospitalization, consultations with hepatology and transplant, re-admission, and death.

**Results.** A total of 166 cases were reviewed; Figure 1 displays the cases per month. The average age was 51 years and 54% were male. The most common symptoms were abdominal pain (47%) and nausea (42.8). Underlying conditions included illicit drug use (23%), alcohol abuse (22%), and diabetes (18.6%). Three percent of cases traveled outside of the state within 2 weeks prior to diagnosis. Twenty-three percent had history of illicit drug use and 4.2% were food handlers. Table 1 displays the healthcare unit where Hep A serology was ordered. One hundred Twenty-two (73.5%) cases were hospitalized, 44 (26.5%) required ICU admission and seven (4.2%) were readmitted within 30 days. Ninety-two cases (55%) required hepatology evaluation, 25 were evaluated for transplantation and one (0.6%) received a liver transplant. Eighteen (10.8%) patients died, two of which were never hospitalized).

**Conclusion.** High clinical suspicion is crucial during an outbreak. Most of our cases were diagnosed with Hep A during inpatient admission after presenting with abdominal pain and nausea. In an outbreak setting, consider testing for immunity from history of previous exposure or vaccination. High hospital admission, morbidity and mortality were seen.

**Figure 1.** Number of cases per month and year.



**Table 1.** Healthcare Unit Where Hep A Serology Was Ordered

Admission	114 (68.6%)
Office visit	31 (18.7)
Lab encounter	13 (7.8)
ED	8 (4.8)
Total	166

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

**2192. Hepatitis A in Greece 2009–2017: Time for Setting New Priorities**

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**Background.** The aim of this study was to present the epidemiological data and describe the outbreaks of hepatitis A identified over the period 2009–2017 in Greece.

**Methods.** Cases recorded through the mandatory notification system were classified in accordance with the European case definition. Data were analyzed by population group (general population, Roma, refugees / migrants, travelers to endemic countries, and MSM).

**Results.** Between 2009 and 2017, 1,072 cases were reported to the Department of Epidemiological Surveillance and Intervention of the Hellenic Center for Disease Control and Prevention. The median annual number of reported cases was 86 (41–277). Reported cases exceeded the expected number in 2013, 2016 and 2017. In 2013 165 cases were reported [three times higher than the mean annual *n* reported for 2005–2012; 101 (61.6%) among Roma]. Three clusters were identified accounting for 50% of reported cases. Genotyping showed that clusters were due to hepatitis A virus subgenotype IA. In 2016, after the closure of the northern borders of Greece in March, 177 cases were reported among refugees (subgenotype IB, the majority of affected of Syrian origin). In 2017, an outbreak among men having sex with men (MSM) was recorded as part of a European HAV outbreak. One hundred and seventy-six male cases were recorded (median age; 38 years old, range; 21–55); 81 identified themselves as MSM. Genotyping data showed linkage to identified European clusters (subgenotype IA).

**Conclusion.** Hepatitis A remains a significant Public Health threat in Greece. Preventive interventions should target populations with low access to healthcare, as well as MSM.

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**2193. Disparities in Hepatitis A Virus (HAV) Vaccination Coverage Among Adult Travelers to High-Risk Countries: The Role of Nativity and Race**

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**Background.** While HAV vaccine is recommended for U.S. travelers, vaccination rates among foreign-born adults are lower than U.S.-born adults. Furthermore, some racial minority groups have low HAV vaccination coverage. We aimed to examine the relationship between nativity, race and their interaction as predictors of HAV vaccination status among adult travelers to high-risk countries (HRCs) through analysis of the National Health Interview Survey (NHIS), 2012–2015.

**Methods.** The study included 44,871 U.S. adult participants in the 2012–2015 NHIS who traveled to countries where HAV is endemic. The main outcome was self-reported HAV vaccination (≥2 doses). Complex survey methods were applied to all models to provide statistical estimates that are representative of U.S. adults. Multivariable logistic regression models adjusting for covariates were fit to examine the association between nativity, race, race-by-nativity (for interaction) and vaccination status.

**Results.** For adult travelers to HRCs, the prevalence of HAV vaccination among foreign-born adults was lower than all adults 13.05% (95% CI; 12.11%, 14.00%) vs. 16.12% (95% CI; 15.60%, 16.64%). The adjusted odds ratio (AOR) of HAV vaccination was lower for foreign-born adults compared with U.S.-born adults 0.86 (95% CI; 0.76, 0.98). For Hispanics, the AOR of HAV vaccination was 0.80 (95% CI; 0.70, 0.91) as compared with non-Hispanic-Whites. Furthermore, a significant qualitative interaction between nativity and race was found (*P*-value < 0.05). Among non-Hispanic Blacks, the adjusted odds of HAV vaccination for foreign-born adults were 1.35 (95% CI; 1.06, 1.72) times the odds for U.S.-born adults. In contrast, the AORs of vaccination of foreign-born vs. U.S.-born adults were 36% (95% CI; 17%, 51%) and 30% (95% CI; 12%, 44%), lower for Asians and Hispanics, respectively.

**Conclusion.** The association between nativity and HAV vaccination status differs by race among travelers to HRCs, with U.S.-born non-Hispanic Black and foreign-born Asian and Hispanic adults having lower vaccination odds. Healthcare resources should be focused on these target populations to improve travel vaccination compliance. Nativity and race should be both assessed when analyzing and reporting HAV vaccination statistics for adult travelers.

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**2194. Hepatitis B Care Cascade Within the VA Maryland Healthcare System**

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