Methods. We performed a retrospective cohort study of overweight and obese (OW) children compared to underweight and normal weight (NW) children with severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) infection. Children between 2 and 18 years of age who were admitted to Texas Children's Hospital from April through December of 2020 with a positive SARS-CoV-2 polymerase chain reaction test were included. Asymptomatic patients undergoing surveillance testing for SARS-CoV-2 were excluded. Body mass index (BMI) was calculated using the Centers for Disease Control definition. Demographic and clinical information was obtained from the electronic medical record. Statistical analyses were performed using SAS 9.0.

Results. We identified 145 total children who met inclusion criteria. Fifty-five (38%) children were NW and 90 (62%) children were OW. Demographics and characteristics are shown (Figure 1). Underlying asthma or chronic lung disease was present in 13 (24%) vs 31 (34%) in the NW and OW groups respectively (P=0.17). OW children were more likely to have pneumonia than NW children [relative risk1.6 (CI 1.40-2.45)]. An elevated BMI was also associated with an increased risk of requiring oxygen [relative risk 1.4 (CI 1.03-1.96)]. The median length of hospitalization was 4 days for NW versus 5 days for OW children (P=0.6). Admission to the Intensive Care Unit (ICU) was similar between the groups (P=0.7). There was no significant difference in treatments administered to children in the two groups, although there was a trend towards increased steroid (29 (53%) vs 59 (67%), P=0.13) and remdesivir (12 (22%) vs 30 (33%), P=0.14) use in the OW children. Four children in each group died.

Characteristics of Hospitalized Children with SARS-CoV-2 Infection by Weight Category

Demographic or Characteristic	Underweight or Normal Weight N=55	Overweight or Obese N=90	P-value ^a
Sex, male	22 (40)	46 (51)	0.2
Race	(,		
American Indian	0 (0)	1 (1)	0.2
and Alaskan Native	- (-)		
Asian	2 (4)	0 (0)	
Black	9 (16)	22 (24)	
White	40 (73)	65 (72)	
Mixed Race	2 (4)	0 (0)	
Unavailable	2 (4)	2 (2)	
Ethnicity			
Hispanic	30 (56)	56 (62)	0.5
Non-Hispanic	24 (44)	34 (38)	19548183 1
Age (median, Q1-	10 (4-14)	13 (9-16)	0.005 ^{b*}
Q3) years	10 (4-14)	13 (9-10)	0.005-
Temperature ≥ 38°C	43 (78)	69 (77)	0.8
Pneumonia	18 (33)	47 (52)	0.02*
Oxygen requirement	22 (40)	52 (58)	0.04*
above baseline			
Highest oxygen			
requirement			
NC	7 (13)	19 (21)	0.07
High flow NC	4 (7)	12 (13)	
Noninvasive MV	4 (7)	10 (11)	
MV	6 (11)	17 (19)	
Other ^o	2 (4)	4 (4)	
Duration of			
intubation	16.5 (2-38)	9 (6-17)	0.9 ^b
(median, Q1-Q3)			
days	00 (05)	50 (00)	
ICU admission	36 (65)	56 (62)	0.7
Length of hospital		5 (0.14)	
stay (median, Q1-	4 (3-8)	5 (2-11)	0.6
Q3) days	15 (07)	(0.00)	
Classified as MIS-C	15 (27)	18 (20)	0.3
Pressor support	8 (15)	16 (18)	0.7
ECMO support	1 (2)	2 (2)	1
Lived	51 (93)	86 (96)	0.5

Abbreviations: ECMO, extracorporeal membrane oxygenation; ICU, intensive care unit; MIS-C, multisystem inflammatory syndrome in children; MV, mechanical ventilation; NC, nasal cannula *Denotes statistically significant P-value a. Calculated using chi-square or fisher exact unless otherwise noted. a. Calculated using chi-square or fisher exact unless otherwise noted. A P-value <0.05 was considered significant. b. Calculated using Wilcoxon rank sum test. c. Includes patients with home noninvasive MV (2) or tracheostomy and home MV(4).

Conclusion. For children admitted with symptomatic COVID-19, being overweight or obese was significantly associated with having pneumonia and with requiring oxygen. A difference in ICU admission, length of hospitalization, and mortality was not observed. Obesity prevention along with vaccination efforts may prevent COVID-19 related morbidity in this group.

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482. SARS-CoV-2 Prevalence in Feces of Very Young Children, A Longitudinal Study

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

Background. Understanding the disease burden of SARS- CoV-2 in young children has been challenging as the majority are asymptomatic or experience mild

symptoms and were rarely tested. SARS-CoV-2 is traditionally detected through respiratory secretions but has also been reported in feces where shedding may continue for weeks after respiratory samples show resolution. We examined the prevalence of SARS-CoV-2 in already collected fecal samples from young children through the pandemic as well as associated demographic factors.

Methods. As part of an ongoing longitudinal microbiome study in Northern Virginia, serial stools samples were collected from infants before and throughout the Covid-19 pandemic. Reverse transcription quantitative-PCR detecting SARS-CoV-2 nucleocapsid gene in the N1 and N2 regions was performed. Penalized logistic regression models were developed to evaluate the association between fecal positivity and potential risk factors.

Results. The overall prevalence of SARS-CoV-2 in infant feces was 1.69 % (13 samples) with a prevalence at delivery, 2, 6, 12 and 24 months of 0, 0, 2.56, 1.96, and 0.85 % respectively. Fecal positivity was first detected 31 days before the reported first case of Covid-19 in Northern Virginia; prevalence rates peaked in September at 4.5% (Figure 1). Only one infant who tested positive was symptomatic with COVID-19 21 days before his stool was collected. Of the 13 positive samples, 8 reported Hispanic ethnicity and 7 reported an essential worker (Table 1). Penalized logistic regression model showed association between Hispanic ethnicity and testing positive (OR 5.04 (95% CI 1.7 – 15.0)) that remained after controlling for the presences of an essential worker (OR 4.7 (95% CI 1.6 – 14.0)).

Table 1: Characteristics of the study cohort compared among negative and positive Sars-CoV-2 cases

Characteristics	Negative (n=582)	Positive (n=13)	P-Value
Hispanic Ethnicity	23.4%	61.5%	0.006
Household Member Diagnosed with Sars-CoV-2	3.6%	0.0%	0.5
Childcare Outside of the Home During Quarantine	20.0%	16.7%	0.7
Symptomatic Infant, Sars-CoV-2 Untested	10.0%	0.0%	0.2
Household with Essential Worker During Quarantine	51.3%	58.3	0.6



Conclusion. Prevalence of SARS- CoV-2 in infant stool correlated with the prevalence of COVID-19 during the pandemic, with higher rates in those of Hispanic ethnicity corelating with regional trends. Fecal positivity in asymptomatic infants even before quarantine restrictions supports the early but silent transmission of SARS-CoV-2. This study likely underestimates true prevalence rates as stool samples were stored without viral preservative. There are many socioeconomic factors that predispose to disease while ethnicity may be a mediating or confounding factor

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483. Disease Severity and Clinical Manifestations of SARS-CoV-2 Infection Among Infants Over the First Year of the Pandemic in Canada Pierre-Philippe Piché-Renaud, MD¹; Luc Panetta, MD²; Daniel Farrar, MPH³; Charlotte Moore Hepburn, MD⁴; Olivier Drouin, MDCM MsC MPH⁵; Fatima Kakkar, MD MPH⁵; Shaun Morris, MD, MPH, DTM&H, FRCPC, FAAP⁶; ¹The Hospital for Sick Children, Toronto, Toronto, Ontario, Canada; ²Hôpital Femme Mère Enfant, Lyon, France, Lyon, Auvergne, France; ³Centre for Global Child Health, Toronto, Ontario, Canada; ⁴Hospital for Sick Children, Toronto, Ontario, Canada; ⁵CHU Sainte-Justine, Montreal, Quebec, Canada; ⁶Hospital for Sick Children, University of Toronto, Toronto, Ontario, Canada

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

Background. There is limited data on outcomes of SARS-CoV-2 infection among infants (< 1 year of age). In the absence of any approved vaccines for infants, understanding the risk factors for hospitalization and severe disease from COVID-19 in this age group will help inform clinical management and targeted public health interventions. The objective of this study was to describe the clinical manifestations, disease severity, and risk factors for hospitalization among infants with SARS-CoV-2 infection in Canada.

Methods. This is a nationwide prospective observational study using the infrastructure of the Canadian Paediatric Surveillance Program. All cases of infants aged < 1 year of age with microbiologically confirmed SARS-CoV-2 infection were reported from April 8th 2020 to May 11th 2021, and classified by disease severity, and primary 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).

Characteristics, n (% _{row})	COVID-19 requiring admission ¹		OR (95% CI)			p-value
	No (N = 229)	Yes (N = 108)	OR (95% CI)	p-value	aOR (95% CI) ²	p-value
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-	107 ((0.0)	70 (0 (0)	4 40 40 00 0 74	0.040	1 (0 (0 30 0 05)	
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
	Disease Category ⁴					
Characteristics, n (%vou)	Non-severe COVID-19	Severe COVID-19	OR (95% CI)	p-value	aOR (95% CI) ²	p-value
	(N = 306)	(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		

aOR - Adjusted didsratis, OR - Odds atio. Asterials (*) denote p=0.05. "Excludes 25 patients admitted for reasons other than COVID-19 and four patients with reason for admitted due to incomplete reports. "Nuthranizile analysis of COVID-19 admits concordered among 252 patients. Nalysis of severe COVID-19 net conducted due to the small number of infants with se

Siease. Age category not determined for 4 infants (3 outpatients and 1 inpatient; 4 non-severe COVID-19). Gestational age category not available for 4 infants (2 outpatients and 2 COVID-19 admissions: 4 non-severe COVD-19).

COVID-19 admissions: A non-severe COVID-191, "Dissecutionary was defined using the Deng-ritrini. Non-severe COVID-19 included mild disease (symptoms present, but without respiratory disters, or any abnormal radiological finding) and moderate disease (patients Non-severe COVID-19 included severe disease (patient) without respiratory disters, and a basice abner gain and moderate disease (patients who experiment). Severe COVID-19 included severe disease (patients who experimente basice abner gain and patients was an ender the severe severe abner gains and the severe disease (patients who experimente requiring supdemental expense (and critical disease (patients admitted to intensive care unit (ICU) or requiring ventilation and/or experimented dinical features of shock or other orcan involvements.

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.

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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

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 so-dium 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.

	All Children	MIS-C	Non-MIS-C	
Characteristic	(n=128)	(n=45)	(n=83)	P-value
Age, years-mean (SD)	9.2 (5.6)	9.6 (4.3)	9.0 (6.2)	0.60
Sex, male—no. (%)	76 (59.4)	26 (57.8)	50 (60.2)	0.78
Race—no. (%)				
White	90 (70.3)	29 (64.4)	61 (73.5)	0.50
Black	15 (11.7)	7 (15.6)	8 (9.6)	
Other	23 (18.0)	9 (20.0)	14 (16.9)	
Ethnicity—no. (%)	20 (1010)	- ()		
Hispanic/Latino	16 (12.5)	6 (13.3)	10 (12.1)	0.91
Weight (kg)—mean (SD)	39.5 (28.9)	42.1 (29.1)	38.1 (28.8)	0.44
Height (cm)—mean (SD)	132.2 (33.7) ^a	137.2 (24.4)	129.4 (37.7) ^b	0.21
Body mass index—mean (SD)	19.8 (6.7) ^a	20.2 (7.5)	19.6 (6.3) ^b	0.61
Past medical history—no. (%)	1010 (011)	2012 (110)	1010 (010)	0.01
Asthma/reactive airway disease	12 (9.4)	2 (4.4)	10 (12.1)	0.15
SARS-CoV-2 exposure/disease	12 (3.4)	2 (4.4)	10 (12.1)	0.10
history—no. (%)	55 (43.0)	32 (71.1)	23 (27.7)	<0.00
Vital Signs—no. (%)	00 (40.0)	02 (71.1)	20 (21.17)	-0.00
Fever	123 (96.1)	45 (100)	78 (94.0)	0.09
Fever duration, days—mean (SD)	5.9 (5.4)	5.2 (1.9)	6.3 (6.7)	0.09
Maximum temperature, Fahrenheit-	5.9 (5.4)	5.2 (1.9)	0.3 (0.7)	0.20
mean (SD)	103.1 (1.5)°	103.3 (1.2)	103.0 (1.6)9	0.31
Hypotension	52 (40.6)	35 (77.8)	17 (20.5)	<0.00
Mucocutaneous and lymphatic	02 (40.0)	00 (11.0)	11 (20.0)	-0.00
signs/symptoms-no, (%)				
Sore throat	32 (25.2) ^h	10 (22.7)	22 (26.5)	0.64
Bilateral conjunctival injection	53 (41.7) ^h	24 (54.6)	29 (34.9)	0.03
Oral mucosal changes	48 (38.1) ^a	16 (37.2)	32 (38.6)	0.88
Unilateral cervical adenopathy				
(>1.5 cm)	4 (3.2) ^a	1 (2.3)	3 (3.6)	0.69
Hepatomegaly/Splenomegaly	4 (3.2) ^a	0 (0)	4 (4.8)	0.14
Rash (any)	71 (55.5)	30 (66.7)	41 (49.4)	0.06
Cardiac signs—no. (%)				
Abnormal cardiac exam	47 (36.7)	22 (48.9)	25 (30.1)	0.03
Heart rate-mean (SD)	119.8 (27.3) ^k	125.2 (22.4)	116.3 (29.7)	0.09
PR interval-mean (SD)	134.3 (29.8) ^o	139.2 (38.7)	131.1 (22.1)	0.16
PR/HR ratio-mean (SD)	1.2 (0.5) °	1.2 (0.4)	1.2 (0.5) ¹	0.47
Respiratory signs/symptoms—no. (%)				
Cough	41 (32.0)	14 (31.1)	27 (32.5)	0.87
Dyspnea	21 (16.4)	7 (15.6)	14 (16.9)	0.84
Abnormal respiratory exam	18 (14.4) ^a	7 (15.6)	11 (13.8) ⁶	0.45
Gastrointestinal signs/symptoms—no.				
(%)				
Diarrhea	53 (41.4)	24 (53.3)	29 (34.9)	0.18
Abdominal Pain	67 (52.3)	33 (73.3)	34 (41.0)	0.00
Nausea	51 (39.8)	23 (51.1)	28 (33.7)	0.16
Vomiting	69 (53.9)	27 (60.0)	42 (50.6)	0.41
Abnormal abdominal exam	38 (29.7)	18 (40.0)	20 (24.1)	0.11
Acute abdomen	3 (2.3)	2 (4.4)	1 (1.2)	0.17
Hematochezia	1 (0.8)	0 (0)	1 (1.2)	0.69
Neurological symptoms—no. (%)	07 (50 0)h	00 (04 4)	00 (15 0)m	
Headache Neek poin	67 (52.8) ^h	29 (64.4)	38 (45.3) ^m	0.05
Neck pain	19 (15.1) ^a	8 (17.8)	11 (13.6) ^b	0.52
Musculoskeletal signs/symptoms—no. (%)				
%) Edema of hands/feet	20 (15.8) ^h	6 (13.3)	14 (17.1) ^m	0.58
Arthritis	20 (15.8) ⁿ 5 (3.9) ^h	1 (2.2)	4 (4.9) ^m	0.56
Arthralgia	18 (14.2) ^h	5 (11.1)	13 (15.9) ^m	0.46
Myalgia	39 (30.5)	20 (44.4)	19 (22.9)	0.01

Abbreviations: MIS-C, multisystem inflammatory syndrome in children; SARS-CoV-2, severe acute respiratory syndrome coronavins 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, m=126, m=126, m=19, m=74, m=113, m=40, m=73, tm=127, tm=44, tm=43, tm=114, tm=69, tm=82

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

	All Children	MIS-C	Non-MIS-C	
Laboratory Value-mean (SD)	(n=128)	(n=45)	(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, x10 ³ /µL	260.6 (146.2)	186.7 (63.3)	300.6 (162.3)	< 0.001
Neutrophils %	71.4 (17.8) ^a	82.1 (7.0) ^b	65.5 (19.3)°	< 0.001
Absolute neutrophils, x10 ³ /µL	8.4 (5.8)	8.7 (4.6)	8.3 (6.4)	0.682
Absolute lymphocytes, x10 ³ /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)°	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)°	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)°	0.180
ALT, unit/L	50.0 (95.4) ^d	35.7 (24.9)	57.9 (116.9)°	0.212
Lactate dehydrogenase, unit/L	432.5 (226.8)	384.3 (125.0) ^a	472.2 (279.8)h	0.063
C-reactive protein, mg/L	135.4 (103.7) ^d	190.5 (98.4)	105.2 (94.2)°	< 0.001
Erythrocyte sedimentation rate, mm/hr	48.1 (30.9)	49.5 (23.0)	47.2 (34.8) ^k	0.697
Troponin, ng/mL	0.6 (3.3) ^k	0.8 (4.0)	0.5 (2.7)9	0.621
B-type natriuretic peptide, pg/mL	270.5 (640.1)	452.1 (778.4)	159.5 (513.5)m	0.016
Ferritin, ng/mL	729.3 (1484.4) ⁿ	637.2 (447.5) ⁹	799.5 (1936.9)°	0.596
Fibrinogen, mg/dL	504.9 (161.6) ⁸	568.7 (147.1)	448.0 (153.7) ^u	< 0.001
Neutrophils with vacuolization/toxic granulation—no. (%)	33 (25.8)	18 (40.0)	15 (18.1)	0.007
Electrocardiogram abnormal—no. (%) Echocardiogram—mean (SD)	47 (43.1) ^v	23 (56.1) ^w	24 (35.3) ^x	0.034
Left ventricle ejection fraction-no.% Coronary artery ectasia-no. (%)	57.1 (10.6) ^y	52.9 (9.1) ^z	60.1 (10.7) ^{sa}	<0.001
Right main coronary artery	7 (8.3)bb	0 (0)	7 (14.9)	0.014
Left main coronary artery	2 (2.2)∞	0 (0)	2 (3.9) ^{dd}	0.210
Left anterior	6 (8,7)	0 (0)	6 (14.3)mm	0.040
Coronary z score-mean (SD)	- ()	- (-)	- ()	
Right main coronary artery	1.2 (3.1) ^h	0.7 (0.8) ⁿⁿ	1.6 (4.0) ⁿⁿ	0.410
Left main coronary artery	0.09 (1.0)00	-0.1 (0.9)	0.2 (1.1)PP	0.297
Left anterior	1.2 (3.3)w	0.2 (1.0)99	1.7 (3.9) ^{rr}	0.166
Abbreviations: ALT alanine aminotransferase: AST as				

Abbreviations: ALT, atasine maintornarferate, AST, apartate anniotransferate, BUN, blood ures nitrogen, SD: transdard deviation. P-variase were classified using tro-sample-tests allowing usequal variances for continuous and Pearano 7 test for estepsical variables, alpha set at <005; 'w=124, "h=44, 'ess0, 'w=127, 'w=22, 'w=93, 'g=42, 'b=51, 'w=119, 'w=116, 'w=12, 'w=97, 'w=97, 'w=97, 'w=93, 'w=54, 'w=64, 'w=109, "w=41, 'w=68, 'w=50, 'h=40, 'h=55, 'w=14, 'w=14, 'w=16, 'w=72, 'w=97, 'w=97, 'w=53, 'w=54, 'w=54, 'w=14, 'w=16, 'w=109, ''w=11, 'w=16, 'w=72, 'w=97, 'w=72, 'w=93, 'w=74, 'w=64, 'w=109, ''w=14, 'w=16, 'w=17, 'w=14, 'w=16, 'w=12, 'w=14, 'w=16, 'w=17, 'w=14, 'w=16, 'w=12, 'w=14, 'w=16, 'w=17, 'w=14, 'w=16, 'w=12, 'w=14, 'w=16, 'w=17, 'w=17, 'w=14, 'w=16, 'w=17, 'w=14, 'w=16, 'w=12, 'w=14, 'w=16, 'w=17, 'w=14, 'w=14, 'w=16, 'w=17, 'w=14, 'w=16, 'w=16, 'w=17, 'w=14, 'w=16, 'w=16,

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.

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