Figure 1. Cumulative enrollment of subjects by day
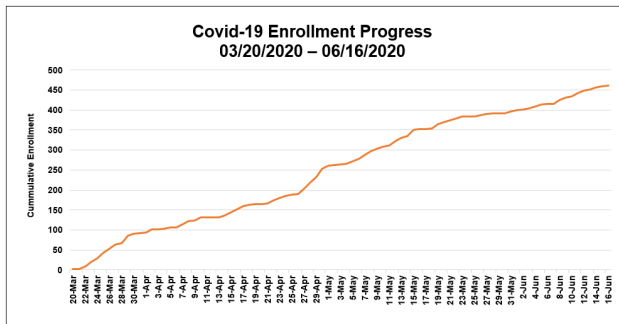

Covid-19 Enrollment Progress
03/20/2020 – 06/16/2020

Table 1. Sociodemographic characteristics among confirmed and suspected COVID-19 cases

	Adult-confirmed n=164	Adult-suspected n=111	P-value	Pediatric-confirmed n=13	Pediatric-suspected n=78	P-value
Age, years, median [IQR]	40.9 [33.1-51.9]	41.0 [34.4-46.8]	0.297	9.5 [6.8-10.8]	7.5 [3.7-10.8]	0.301
Sex, Male	87/163 (53%)	51 (46%)	0.227	7 (54%)	42 (54%)	1.000
Race, White	137/160 (86%)	105 (95%)	0.011	10/11 (91%)	73 (94%)	0.830
Ethnicity, Hispanic	28 (17%)	6 (5%)	0.004	3 (23%)	4/77 (5%)	0.026
Underlying medical condition(s)	77 (47%)	38 (34%)	0.036	4 (31%)	12 (15%)	0.177
Smoking	14 (9%)	5 (5%)	0.196	0	0	--
Smoke exposure	23/163 (14%)	9/110 (8%)	0.135	3 (23%)	3/77 (4%)	0.010
Travel*	69/163 (42%)	56/110 (51%)	0.163	1 (8%)	27/77 (35%)	0.049

Footnote: * Travel denotes anywhere out of Nashville since January 1, 2020

Figure 2. Adults and pediatrics, confirmed and suspected cases, by clinical presentation
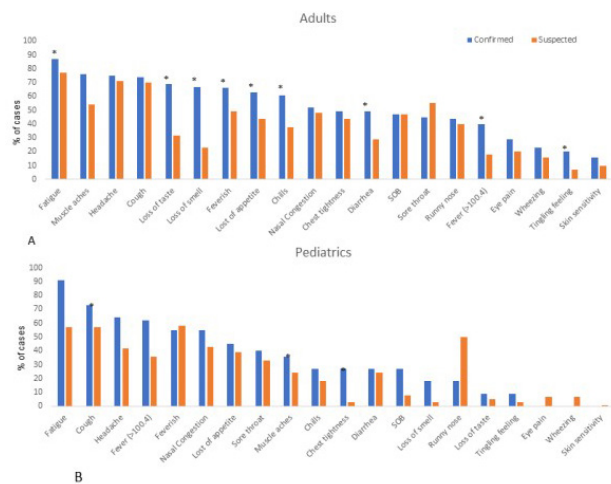
Footnote: *denotes p-value <0.05 for the pairwise comparison between confirmed and suspect cases.

Conclusion: We observed differences of clinical presentation between confirmed and suspected cases among both pediatric and adult participants. Further research is needed to determine whether these differences are due to disease severity or absence of proven COVID-19. We are collecting serial nasal swabs, blood and stool specimens, on which future testing will confirm SARS-CoV-2 infection in suspected subjects.

59. Persistence of Respiratory and Non-respiratory Symptoms Among COVID-19 Patients Seeking Care at an Ambulatory COVID-19 Center

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Background: While hospitalized COVID-19 patients are well described in the literature, studies of the natural history and ambulatory cases are limited. We aim to describe the symptoms and clinical course of COVID-19 among ambulatory patients seen at the Emory University multidisciplinary Acute Respiratory Clinic (ARC) developed to care for patients with confirmed or suspected COVID-19.

Methods: PCR-confirmed COVID-19 cases seen at ARC from 4/3–5/16/2020 were included in a retrospective chart review. Encounters were classified as acute, subacute, or convalescent depending on the duration since illness onset (< 1, 1–4, or >4 weeks, respectively). Demographic, clinical, physical exam, diagnostic test, and disposition data were abstracted and analyzed with standard descriptive statistics.

Results: Among 404 visits at ARC, 127 (31.4%) were for confirmed COVID-19 illness (107 unique patients with 1–4 visits). The majority (75.7%) of patients were female, and the median age was 55 years (range 24–89). Patients presented during acute, subacute, and convalescent phases of illness (15.7%, 58.3%, and 26.0%, respectively; Table). Prevalent co-morbidities included hypertension (39.3%), obesity (27.1%), diabetes (20.6%), and asthma (21.5%). While measured or subjective fever was reported in the majority of acute visits (60.0%), it was less common in subacute and convalescent encounters (27.0% and 30.3%). Cough was commonly reported in acute, subacute, and convalescent visits (70.0%, 79.7%, 66.7%), as were dyspnea on exertion (45.0%, 70.3%, 66.7%) and chest tightness (40.0%, 40.5%, 60.6%). Although smell or taste alteration was present in almost half of acute and subacute patients, it was only reported in a quarter of convalescent patients. Among the three stages of illness, transfers from ARC to the ED or direct hospitalizations occurred in 15.0%, 23.0%, and 12.1% of acute, subacute and convalescent visits, respectively.

Table: Timecourse of Symptoms among COVID-19 Patients in the Ambulatory Context

Symptom	All patients n=127	Illness Stage		
		Acute (n=20)	Subacute (n=74)	Convalescent (n=33)
Fever	42 (33.1)	12 (60.0)	20 (27.0)	10 (30.3)
Chills	31 (24.4)	8 (40.0)	17 (23.0)	6 (18.2)
Body aches	44 (34.6)	12 (60.0)	24 (32.4)	8 (24.2)
Headache	46 (36.2)	9 (45.0)	29 (39.2)	8 (24.2)
Sore throat	24 (18.9)	5 (25.0)	13 (17.6)	6 (18.2)
Rhinorrhea	9 (7.1)	5 (25.0)	3 (4.1)	1 (3.0)
Nasal congestion	43 (33.9)	8 (40.0)	25 (33.8)	10 (30.3)
Cough	95 (74.8)	14 (70.0)	59 (79.7)	22 (66.7)
Dyspnea	51 (40.2)	4 (20.0)	33 (44.6)	14 (42.4)
Dyspnea on exertion	83 (65.4)	9 (45.0)	52 (70.3)	22 (66.7)
Chest tightness	58 (45.7)	8 (40.0)	30 (40.5)	20 (60.6)
Wheezing	18 (14.2)	3 (15.0)	13 (17.6)	2 (6.1)
Altered taste or smell	50 (39.4)	9 (45.0)	33 (44.6)	8 (24.2)
Diarrhea	28 (22.0)	6 (30.0)	18 (24.3)	4 (12.1)

Table. Number and percentages of COVID-19 patients reporting symptoms of illness at the time of presentation to the Emory Acute Respiratory Clinic, April 3 to May 16, 2020. Illness stages defined as acute (< 7 days), subacute (7-28 days), or convalescent (>28 days).

Conclusion: Following acute illness, COVID-19 patients can experience persistent symptoms, primarily respiratory symptoms, which can be severe enough to warrant hospitalization. Clinics evaluating recovering patients should prepare to manage these symptoms. Further study of the pathophysiology and treatment of persistent pulmonary symptoms in COVID-19 is needed.

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

60. New Prognostic Markers for COVID-19 Disease

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Background: A few COVID-19 related retrospective studies have established that older age, elevated neutrophil-lymphocyte ratio (NLR), and decreased lymphocyte-CRP ratio (LCR) were associated with worse outcome. Herein, we aim to identify new prognostic markers associated with mortality.

Methods: We conducted a retrospective hospital cohort study on patients ≥ 18 years old with confirmed COVID-19, who were admitted to our hospital between 03/15/2020 and 05/25/2020. Study individuals were recruited if they had a complete CBC profile and inflammatory markers such as CRP, ferritin, D-dimer and LDH, as well as a well-defined clinical outcomes (discharged alive or expired). Demographic, clinical and laboratory data were reviewed and retrieved. Univariate and multivariate logistic regression methods were employed to identify prognostic markers associated with mortality.

Results: Out of the 344 confirmed COVID-19 hospitalized patients during the study period, 31 who did not have a complete blood profile were excluded; 303 patients were included in the study, 89 (29%) expired, and 214 (71%) were discharged alive. Demographic analysis was tabulated in Table 1.