Visitor Restriction Policies and Practices in Children’s Hospitals: Results of an Emerging Infections Network Survey

Alice Pong, University of California
Mekleeta M. Faltamo, Emory University
Susan E. Beekmann, University of Iowa
Philip M. Polgreen, University of Iowa
Andrea Shane, Emory University

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2309. Epidemiology of Meningitis and Encephalitis in Infants and Children in the United States from 2011 to 2014

Rodrigo Hasbun, MD, MPH;1,2,3,4 Jing Rosenthal, MD, MPH2,3; Joan-Miquel Balada-Flastat, PharmD, PhD2; Jessica Chung, PhD MPH2; Steve Duff, MS; Samuel Bozzette, MD PhD2; Louise Zimmer, Research Coordinator1 and Christine Ginocchio, PhD MTH1, Division of Biostatistics, University of Texas Health Science Center at Houston, Mc Govern Medical School, Houston, TX, 2Premier Healthcare Database, Charlotte, North Carolina, 3Clinical Microbiology, The Ohio State University Medical Center, Columbus, Ohio, 4Veritas, Carlsbad, California, 1bioMérieux, Durham, North Carolina

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Background. Large epidemiological studies evaluating the etiologies, management, outcomes and sequelae of infants and children with meningitis and encephalitis in the United States (US) are lacking.

Methods. Infants (<1 year old) and children (1–17 years) with meningitis or encephalitis by principal or secondary discharge ICD-9 diagnosis codes available in Premier Healthcare Database (PHD) during 2011–2014 were analyzed. PHD contains hospital discharge data including discharge diagnoses, diagnostic and treatment procedures, medications, and cost information from over 700 geographically diverse US hospitals. Descriptive statistics were used to describe the characteristics, etiologies, management decisions and outcomes of study population. Statistical comparisons were made between infants and children.

Results. A total of 6,665 patients with meningitis or encephalitis were identified: 3,030 (45%) infants and 3,635 (55%) children. Infants were more likely than children to be hospitalized (91.1% vs 76.3%; P < 0.01) and have lumbar puncture done as an inpatient (22.7% vs 17.0%; P < 0.01). Overall, the most common etiology was enterovirus (36.4%, 58%); followed by unknown (1546, 23.2%), bacterial meningitis (869, 13.0%), non-infectious (209, 3.1%), herpes simplex virus (HSV) (103, 1.5%), other viruses (47, 0.7%), arboviruses (36, 0.5%), and fungal (3, 0.05%). Overall, empirical antibiotics (97.7% vs. 85.6%, P < 0.001); P < 0.0001) were more likely to be administered in infants than in children and the use varied by etiologies. Adjunctive steroids were utilized more frequently in children than in infants (11.8% vs. 3.6%, P < 0.001). The overall median length of stay in infants and children was 3 and 2 days, respectively; the longest duration was seen in those infants and children with HSV (20 days/6.6 days), and with bacterial meningitis (1 days/10 days), respectively. Overall, inpatient mortality and readmission rates were low (<1% in both infants and children).

Conclusion. Viruses are the most common cause of meningitis and encephalitis in infants and children and are treated with antibiotic therapy in the majority of cases.

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2310. Quality of Life Following Childhood Bacterial Meningitis in Luanda, Angola

Maria Karpipinen, MD1,2; Emilie Rugemalira, MD1,2; Okko Savonius, MD1,2; Manuel Llasat, Pharm D, PhD3; Jessica Chung, Phd MPH2; Steve Duff, MS4; Samuel Bozzette, MD and Tuula Pelkonen, MD, PhD1,2,3; 1Children’s Hospital, Helsinki University Hospital, Helsinki, Finland, 2Faculty of Medicine, University of Helsinki, Helsinki, Finland, 3Pediatric Hospital, Luanda, Angola, 4Faculty of Medicine, University Diegz de Almagro, Santiago, Chile

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Background. Survivors of childhood bacterial meningitis (BM) from low-income countries are at increased risk of sequelae. How BM survivors’ daily life is affected in the developing world, is not known. We aimed to investigate the quality of life among pediatric survivors of BM in Luanda, Angola assessing both physical and psychosocial health related quality of life (HRQOL).

Methods. Survivors from two BM treatment trials (ISRCTN62824827; NCT01540838) from Luanda Children’s Hospital were called to follow-up visits in January 2017 with a median duration of 26 months after BM. We administered Pediatric Quality of Life Inventory (PedsQL2.3) 4.0 Generic Core Scales and Infant Scales, designed to measure HRQOL in children, to patients and/or parents. The core scales were administered to 64 and 32 families, and the infant scores to 8 and 3 care-givers. One hundred and seventy (51%) of eligible respondents completed a survey between 12 July and 15 August 2016. Of these, 44 (27%) reported not knowing if their facility had a VRP and 17 (10%) reported having a policy but were unfamiliar with details; both groups were excluded from further analyses. 104 (61%) reported being somewhat familiar with the details of their VRP and 92 (58%) had a VRP in all inpatient units. Age-based VRP were reported by 77/104 (74%), symptom-based by 101 (97%), and outbreak-specific by 78 (75%). VRP were also implemented in the emergency department (5%), outpatient clinic by 9 (9%), day surgery by 6 (6%), or radiology by 3 (3%). Symptom-based VRP were seasonal (24% of facilities, with 71% implementing VRP to familiy members at admission and 40% between 89 (87%) and through signage in care areas by 65 (64%). Communication of VRP to staff occurred by email for 79 (77%), by meetings for 56 (55%) and by signage in staff only areas for 50 (50%). Enforcement was the responsibility of nursing (82.5%), regulations (59, 58%), unit clerks (54, 53%), the infection prevention team (32, 31%), or clinicians (16, 16). The effectiveness of VRP was assessed by 63 (62%) through active surveillance of hospital acquired respiratory infections; 29 (28%) used active surveillance of healthcare worker exposures and 30 (29%) used patient/family satisfaction.

Conclusion. VRP vary in scope, implementation, enforcement, and physician awareness in pediatric facilities. The prospective multisite evaluation of outcomes would facilitate the adoption of uniform guidance.

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