availability of previously investigational drugs. Triclabendazole is now FDA approved for treatment of *Fasciola* infection in persons ≥6 years old and benznidazole is now FDA approved for treatment of Chagas disease in children 2–12 years old. Miltefosine has also been approved by FDA for treatment of certain leishmaniasis infections. CDC has successfully pursued expiry extensions of drugs with manufacturers, FDA, and other partners to ensure continued domestic availability of treatment options when there has been no or limited production of newer lots. CDC's Parasitic Diseases Branch can be reached by telephone: 404-718-4745 or email: parasites@cdc.gov.

[1] Pentostam* is made by GlaxoSmithKline

[2] WHO interim guidelines for treatment of gambiense HAT. Geneva: 2019.

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771. Prospective validation of the universal vital assessment (UVA) score to predict the in-hospital mortality of patients with acute illness admitted to a government district hospital in KwaZulu-Natal, South Africa

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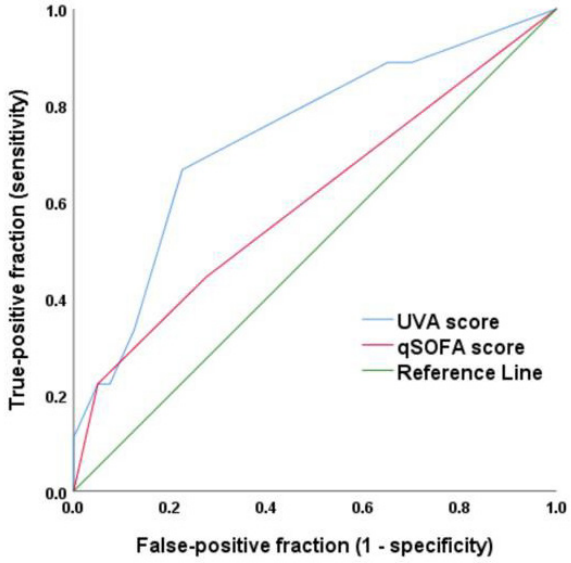
Background: Critical illness is a frequent cause of mortality in resource-limited settings. Improved triage on admission could improve mortality, but existing tools depend on variables that often are not available. We prospectively evaluated the universal vital assessment (UVA) score to predict mortality among patients admitted to a district hospital in rural, highly HIV-prevalent South Africa.

Figure 1. Receiver operator characteristic (ROC) curves for the UVA and qSOFA scoring tools.



	aROC	95% CI	P-value
UVA score	**0.74**	**0.55-0.93**	**0.03**
qSOFA score	**0.60**	**0.38-0.83**	**0.33**

Methods: In February-March 2020, adults admitted to the medical wards were enrolled, prior to interruption by covid19, and 30-day mortality assessed. Clinical parameters including temperature, heart and respiratory rates, systolic blood pressure, oxygen saturation, Glasgow Coma Scale score, and HIV status were collected within 24 hours of admission as part of routine care. Lower respiratory tract infections (LRTI) included pneumonia and suspected pulmonary tuberculosis. To evaluate the predictive ability of the UVA score, area under the receiver operating characteristic curve (aROC) and age-sex adjusted binary logistic regression models were generated, and compared to the sequential organ failure assessment (qSOFA).

Results: Sixty one patients were enrolled; outcomes were available for 56 patients. Patients had a mean age of 52 (SD+17), 51% were women, and 46% were HIV infected. The 30-day mortality was 16.1% (9/56) with infections and non-communicable diseases comprising 47% and 47% of admission diagnoses, respectively. The most common admitting diagnosis was LRTI (24.6%). The median (+IQR) UVA score was 2 (+3) accounting for 36% of participants. Medium-risk (2-4) and high-risk (>4) UVA groups were not associated with 30-day mortality, although the high-risk score trended towards significance (p=0.07). However, a UVA score > 3 was significantly associated with 30-day mortality, both alone and after adjusting for age and sex (aOR 6.2, 95% CI 1.2-33.1; p=0.03). The aROC (95% CI) for the UVA score was 0.74 (0.55 – 0.93), which performed better than qSOFA (aROC 0.59, 95% CI 0.37-0.81) and is shown in **Figure 1**.

Conclusion: In this resource-limited, HIV-prevalent setting, the UVA score predicted mortality better than the qSOFA score. A moderate-risk UVA score (>3) was predictive of 30-day mortality, though needs to be confirmed in larger studies.

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

772. Respiratory Syncytial Virus Acute Respiratory Infections in Young Children in Jordan: A Prospective Surveillance Study

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Background: Respiratory syncytial virus (RSV) is the leading cause of acute respiratory infections (ARI) hospitalizations in young children and is associated with increased severity compared to other viruses. The aim of this study was to evaluate the utilization of a rapid RSV diagnostic test and clinical characteristics and disease severity of children who were hospitalized during one respiratory season in Amman, Jordan.

Methods: Children less than two years hospitalized with fever and/or respiratory symptoms were recruited at Al-Bashir Government Hospital from January 8, 2020, to March 17, 2020. Nasal swabs were collected and tested by Sofia-2 RSV Fluorescent Immunoassay. Demographic information and clinical history were obtained through parental interviews. A validated severity score was used to assess disease severity, and the treating physician prospectively collected the necessary information to calculate the score at admission. Disease severity was categorized based on the total score into 0-5 mild, 6-9 moderate, and ≥ 10 severe. Molecular testing and medical chart reviews are still in process.

Results: A total of 532 subjects were enrolled, and nasal swabs were collected and tested from 458 (86%) of enrollees. The most common admission diagnoses were pneumonia (25%), bronchopneumonia (21%), bronchiolitis (19%) and sepsis (17%). Demographic and clinical characteristics are included in **Table 1.** Overall, 276 (60%) subjects were RSV-positive. The most common admission diagnoses were pneumonia (33%), sepsis (25%), bronchiolitis (24%) and bronchopneumonia (24%). Compared to RSV-negative children, RSV-positive children were younger **(Table 1),** and more likely to present with cough, nasal congestion, and appetite loss **(Figure 1).** There were no differences in severity score or direct intensive care unit admission between the two groups **(Table 1).**

Table 1. Demographic and Clinical Characteristics of the Study Cohort

	Tested with Sofia n=458	RSV Positive n=276	RSV Negative n=182	P value
Demographic Characteristics				
Age, months, mean ± SD	**4.8± 4.6**	**4.3 ± 3.9**	**5.5 ± 5.4**	**0.02§**
Sex, male	255 (56%)	153 (55%)	102 (56%)	0.90†
Mother smoking during pregnancy	108 (24%)	72 (26%)	36 (20%)	0.12†
Prematurity	78 (17%)	50 (18%)	28 (15%)	0.45†
Current Breastfeeding	293 (64%)	185 (67%)	108 (59%)	0.09†
Household smoke exposure	357 (78%)	220 (80%)	137 (75%)	0.26†
UMCs	45 (10%)	24 (9%)	21 (12%)	0.32†
Clinical Characteristics and Disease Severity				
Illness Duration, days, mean ± SD	3.7 ± 2.1	3.6 ± 2.04	3.8 ± 2.3	0.5§
Maximum RR	48.4 ± 15.34	47.03 ± 15.70	49.28 ± 15.07	0.13§
Minimum O2 Sat.	94.47 ± 6.61	94.6 ± 5.33	94.24 ± 9.20	0.58§
Severity Score*				
Mild	328 (72%)	165 (72%)	113 (74%)	0.137
Moderate	105 (24%)	54 (23%)	38 (25%)	
Severe	14 (4%)	12 (5%)	2 (1%)	
Direct ICU admission	35/457 (8%)	16/275 (6%)	19/182 (10%)	0.07§

Categorial Data are in n (%), Continuous data are in mean ± SD, median [IQR]; ICU: Intensive care unit; IQR: interquartile range

*384 patients had complete data: 231 RSV-positive and 153 RSV-negative

§Pearson's Chi-Squared, † T-test

Figure 1. Symptom Distribution in RSV-Positive and RSV-Negative Subjects