tion was 5.75 days (range 3- 22) and 12.9% need intensive care. Rx exam was performed in 22 children and was suggestive of bacterial infection in 7 (31.81%). Samples for blood culture were taken from 11 children (only 1 positive for CNS). At least one underlying medical condition was found in 35% of children and the most common was congenital heart disease.Two children dead (CFR = 6.25%):both were > 2 y, had underlying conditions (1 cardiac and other pulmonary chronic disease), demanded medical help 5 days after the onset of disease and have not been immunized against pneumococcal, as recommended by National Program of Immunization for at-risk children.

Conclusion: These data suggest that early treatment with oseltamivir and antibiotics can benefit children with ARD and should start early in serious cases and immunocompromised children. About 1/3 of children had radiologic condensation suggestive of co-infection by *S.pneumoniae*.The low positivity rate of blood culture do not exclude infection by this bacteria, because of antibiotic use and low sensitivity of this test. It is necessary to divulgate recommendations for immunization against *S. pneumoniae*, that is offered free of charge for at-risk children in Reference Centers for Immunobiologics, but is underused.

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Novel influenza A 2009 - A comparison of intensive care unit vs non-intensive care unit patients

C. Boehringer

UCSF Fresno, fresno, CA, USA

Background: Novel 2009 influenza A cases were first noted in California in mid April. To our knowledge there are no studies to date, which have reviewed duration of illness, fever, treatments and outcomes. We reviewed patient demographics and clinical characteristics in ICU vs non-ICU patients.

Methods: From June 2009 to October 2009, 41 patients were admitted to our 620 bed teaching hospital and 80 bed community hospital with confirmed H1N1 by rRT- PCR. 16 patients admitted to ICU- and 25 to non-ICU beds. Data was analyzed using multi-logistic regression analysis.

Results: 51.2% Hispanic, 19.5% Caucasian, 17.1% Asian and 12.2% African-American. Seventeen males; 24 females, 8 were pregnant. The mean BMI 33.4 ICU vs 32.3 non-ICU, $p = 0.76$. Mean age for ICU was 43.7 vs 39.6 non-ICU, $p = 0.46$. There were 4 deaths. Fever (>37.8 C) was noted in 75% ICU and 72% non-ICU patients (mean 38.5 ± 0.62 vs 38.9 ± 0.75 respectively). Duration of fever was 4.5 days (± 4.8) vs 2.2 ($\pm$ 2.5) $p = 0.028$. Of ICU patients 43.8% had leukocytosis (mean 19.6). 3 of 25 (12%) floor patients had leukocytosis, mean 8.9 ($p = 0.009$,[95% CI, 1.062, 1.541])). Mean WBC in pregnancy was 9.11 ± 2.3. Duration of illness in ICU patients, from onset of symptoms to day of discharge was 19.93 days ($SD \pm 10.5$) vs of 9.4 days ($SD \pm 4.99$) non-ICU ($p = 0.00013$). Mean days on mechanical ventilation were 14.81 ($SD \pm 12.71$). Days to ER presentation for ICU vs non-ICU patients 3.4 ± 3.0 vs 2.72 ± 1.9 ($p = 0.236$). Antivirals for non-ICU patients was 63%. Three pregnant women did not receive treatment ICU treatment with Oseltamivir was begun a mean of 2.8 days into hospitalization and in non-ICU patients, 3.5 days after hospital admit ($p = 0.52$). Duration of treatment was 9.8 ± 4.3 days and 5.5 days ± 0.92 ICU and non-ICU respectively ($p = 0.0005$) Secondary bacterial infection was found in 2 ICU patients by mini- BAL. One patient with Streptococcus pneumonia, 1 patient with MRSA and Haemophilus Influenzae (12.5%)

Conclusion: Overall mortality was 9.75%, and 18.75% for the ICU. No pregnancy related deaths. All deaths were in ICU patients. A significant increase in length of illness, duration of fever and leukocytosis was seen in ICU patients. No difference was noted in the onset of treatment between the 2 groups but longer treatments in ICU patients were seen.Time of onset of symptoms to ER presentation did not impact outcome. There was no difference in the BMI or age of those in the ICU vs non-ICU.

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Impact of educational measures about influenza A (H1N1) directed to healthcare workers and patients

C. Freuler*, C. Ezcurra, M. Mayer-Wolf, V. Rodríguez, R. Durlach

Hospital Alemán, Buenos Aires, Argentina

Background: The aim of this report is to describe the impact of educational measures during the influenza A(H1N1) pandemic in an acute-care hospital in Buenos Aires.

Methods: This is a retrospective descriptive study based on own data and data from the National Health System during epidemiological weeks 20 to 30 (17th May-1st August).

Results: Because of the influenza epidemic a crisis committee was organized under the leadership of the Infectious Diseases Department and constituted by the heads of the Internal Medicine and Pediatric Departments, the Emergency Room Coordinator, and the head of nurses. They published a daily report and outlined common guidelines about diagnostic and treatment proceedings, prevention measures, and overall hospital performance. A call center with specially trained physicians answering the phone decreased patients and community anxiety, advising asymptomatic patients or patients without risk to stay at home. Visits to hospital patients were restricted to 2 hours per day and suppressed for pregnant women. Alcohol for hand hygiene was offered at hospital entrances. Respiratory masks were given to symptomatic patients until physician's evaluation.

Of 1520 employees, 1083 in contact with patients, only two servants became infected, thus reflecting overall community risk. The hospital cares for 47000 members, 439 (0,93%) were studied because of influenza A(H1N1) suspicion, media age 15 years, 48% men. Forty-one required admission and 3 died.