underlying comorbidities. In our series, there were 2 deaths within 2 weeks of infection.

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Poster Presentation
Subject Category: Respiratory Viruses

Working with Respiratory Illness: Presenteeism Among Healthcare Personnel at Tertiary-Care Hospitals in Bangladesh, 2008–2016

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Background: Healthcare personnel (HCP) in crowded and resource-poor countries (eg Bangladesh), might be at risk of exposure to and transmission of respiratory illnesses to coworkers, patients, and caregivers. The infection control practices in public hospitals are inadequate in Bangladesh. We estimated the incidence of respiratory illness episodes among HCP, and proportion of HCP who worked during respiratory illnesses, including influenza virus infection, at 2 tertiary-care public hospitals in Bangladesh. **Methods:** From May 2008 to February 2016, HCP (defined as physicians, nurses, interns, patient care assistant, cleaners, and administrative staff working in adult and pediatric medicine wards) were asked to self-report to study physicians when they experienced new onset of cough, rhinorrhea, difficulty breathing, or fever during the April–September influenza epidemic period each year. Study physicians followed HCP throughout their respiratory illness episodes and recorded respiratory symptoms, onset dates, duration of illness, and days of presenteeism and absenteeism during illness. Nasopharyngeal and oropharyngeal swabs were collected after informed written consent and were tested for influenza by rRT-PCR. We used hospital records to enumerate total HCP working in the study wards during influenza season and multiplied by 6-months follow-up per year to calculate person-time contribution for estimating respiratory illness incidence. **Results:** HCP self-reported 107 episodes of respiratory illness during 656 person years of follow-up, for an estimated incidence of 16.3 per 100 person years (95% CI, 13–20). Of 107 episodes, 33 (31%) included fever and cough. The mean illness length was 3.9 days (SD, ±1.8). HCP worked an average of 3.4 days (SD, ±1.4) while ill. HCP missed work for a median of 1 day (IQR, 1–2) during 29 (27%) of 107 illness episodes. HCP consented to collect swabs during 56 (52%) episodes, and among them 8 (14%) of 56 tested positive for influenza (flu-A, n = 5; flu-B, n = 3). Also, 63% of HCP with influenza reported fever and cough. HCP experiencing either respiratory illness or influenza worked for similar periods of days while ill: mean, 4 (SD, ±2.2) versus mean, 3.3 (SD, ±1.4) ($P = .257$). HCP worked during 105 (98%) of 107 respiratory illness and 7 (88%) of 8 influenza episodes. **Conclusions:** Most HCP in Bangladesh, including those with influenza, worked during respiratory illnesses. The potential value of stay-at-home policies, compensation for sick days, and influenza vaccination in reducing HCP-associated respiratory pathogen transmission could be assessed in Bangladesh and similar settings.

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Respiratory Syncytial Virus: An Underrecognized Healthcare-Associated Infection

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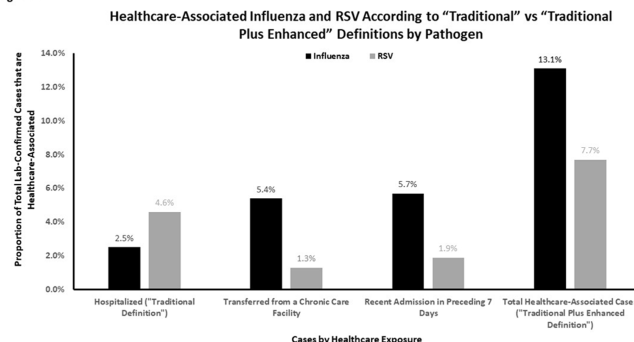
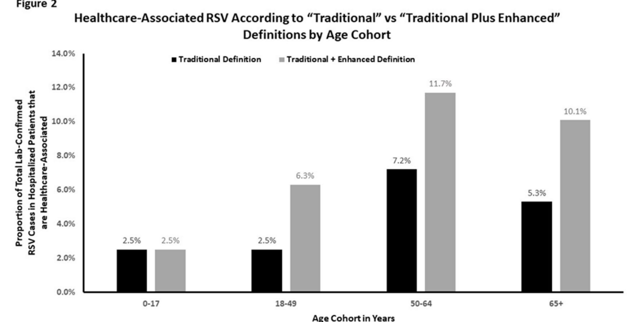
Background: Despite significant morbidity and mortality, estimates of the burden of healthcare-associated viral respiratory infections (HA-VRI) for noninfluenza infections are limited. Of the studies assessing the burden of respiratory syncytial virus (RSV), cases are typically classified as healthcare associated if a positive test result occurred after the first 3 days following admission, which may miss healthcare exposures prior to admission. Utilizing an expanded definition of healthcare-associated RSV, we assessed the estimates of disease prevalence. **Methods:** This study included laboratory-confirmed cases of RSV in adult and pediatric patients admitted to acute-care hospitals in a catchment area of 8 counties in Tennessee identified between October 1, 2016, and April 30, 2019. Surveillance information was abstracted from hospital and state laboratory databases, hospital infection control databases, reportable condition databases, and electronic health records as a part of the Influenza Hospitalization Surveillance Network by the Emerging Infections Program. Cases were defined as healthcare-associated RSV if laboratory confirmation of infection occurred (1) on or after hospital day 4 (ie, "traditional definition") or (2) between hospital day 0 and 3 in patients transferred from a chronic care facility or with a recent discharge from another acute-care facility in the 7 days preceding the current index admission (ie, "enhanced definition"). The proportion of laboratory-confirmed RSV designated as HA-VRI using both the traditional definition as well as with the added enhanced definition were compared. **Results:** We identified 900 cases of RSV in hospitalized patients over the study period. Using the traditional definition for HA-VRI, only 41 (4.6%) were deemed healthcare associated. Adding the cases identified using the enhanced definition, an additional 12 cases (1.3%) were noted in patients transferred from a chronic care facility for the current acute-care admission and 17 cases (1.9%) were noted in patients with a prior acute-care admission in the preceding 7 days. Using our expanded definition, the total proportion of healthcare-associated RSV in this cohort was 69 (7.7%) of 900 compared to 13.1% of cases for influenza (Figure 1). Although the burden of HA-VRI due to RSV was less than that of influenza, when stratified by age, the rate increased to 11.7% for those aged 50–64 years and to 10.1% for those aged ≥65 years (Figure 2). **Conclusions:** RSV infections are often not





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