included in estimates of HA-VRI, but the proportion of cases that are healthcare associated are substantial. Typical surveillance methods likely underestimate the burden of disease related to RSV, especially for those aged ≥50 years.

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Presentation Type:
Poster Presentation
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Facemasks for Source Control: Testing Influenza Transfer to Bedside Tables

Adriane Biggio and Stephanie Nagy-Agren

Background: Research testing human study participants regarding the effectiveness of face masks in preventing influenza transfer or transmission is limited. In this pilot study, we investigated the following question: In influenza-positive veterans, what is the effect of face-mask wearing in comparison to not wearing a face mask on influenza transfer to bedside tables measured for 2 hours per condition over a 10-week period during the 2019–2020 influenza season **Methods:** Influenza-positive veterans with influenza symptom onset ≤ 120 hours admitted to the Salem Veterans Affairs Medical Center were recruited to participate in this study. Exclusion criteria included critical illness requiring an oxygen mask or intubation. The Precept® FluidGard® 160 Procedure Mask 15300, Precept Medical Products, Inc., Arden, NC was worn by all participants during the two-hour intervention period. Surface swabs were used to measure the presence of influenza on bedside tables. CDC/NIOSH tested for influenza A and B from surface samples and facemasks using real-time polymerase chain reaction (PCR) assay (TaqMan ThermoFisher Scientific). Demographic information was collected (Table 1). A study questionnaire collected qualitative data on tolerability and feasibility of wearing a facemask when hospitalized with influenza. Institutional Review Board approval was granted. **Results:** From January 2, 2020, to March 11, 2020, 8 participants completed the study. Mean age was 67 years, all were male. Of these 8 participants, 6 had influenza A and 2 had influenza B. Half were diabetic; all received oseltamivir. Relative room humidity ranged from 15.6% to 39.8%. Neither influenza A nor B was detected by qPCR on bedside tables for any of the 8 participants under either face-mask–wearing condition. All participants reported that wearing the face mask was easy or very easy; of these, 5 reported experiencing warmth from the mask. Also, 50% of participants selected 2 hours as the time they could tolerate wearing a mask; the other 25% specified they could wear the face mask for 3 hours or 5 hours or more, respectively. **Conclusions:** In this pilot study, we demonstrated that wearing face masks is a tolerable infection control practice for providing source control for inpatients with influenza and will guide future research. Because a major limitation was the small size of the study, associated with lack of viral capture, a larger study is planned. Using face masks for source control among inpatients with influenza and other respiratory virus infections should be considered a standard infection control practice.

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Table 1.

Participant age, influenza type, temperature, oseltamivir doses received, and pertinent medical history.

Participant	Age (years)	Influenza type	T_{max} on study date	Oseltamivir (# doses received)	Pertinent medical history
1	67	B	99.7	2	COPD, diabetes, cigarette smoking
2	72	A	98.5	2	
3	84	A	98.4	2	
4	86	B	98	2	
5	69	A	98.1	2	COPD, diabetes
6	70	A	98.4	2	pneumonia, COPD, cigarette smoking
7	59	A	98.4	4	
8	27	A	100.3	1	cigarette smoking

Table 2.

Number of hours tolerated facemask-wearing condition, general experiences wearing facemask, and opinion about ease or difficulty wearing the facemask

	N (%)
Two hours	4 (50)
Three hours	2 (25)
Five hours or more	2 (25)
Warmth	5 (62.5)
General discomfort	3 (37.5)
Shortness of breath	1 (12.5)
No discomfort	2 (25)
Easy or very Easy	8 (100)

Table 3.

Influenza A or B Detection on Nasopharyngeal Swabs, Masks, and Bedside Tables

N=8	Nasopharyngeal swab (total M1 copies in sample)	Worn mask	Before mask intervention	After mask intervention	Before unmasked intervention	After unmasked intervention
1	DNQ*	UD	UD	UD	UD	UD
2	2.40E+03	DNQ	UD	UD	UD	UD
3	46.0	UD	UD	UD	UD	UD
4	UD	NA	NA	NA	NA	NA
5	2.94E+03	DNQ	UD	UD	UD	UD
6	no sample	DNQ	NA	NA	NA	NA
7	2.64E+02	UD	UD	UD	UD	UD
8	UD	UD	NA	NA	NA	NA

DNQ = detectable but not quantifiable
*denotes influenza B
UD = undetected
NA = not assayed

Presentation Type:
Poster Presentation
Subject Category: SSI

Incidence and Risk Factors for Surgical Site Infection Following Coronary Artery Bypass Graft Procedures

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Background: Deep and organ-space surgical site infections (SSIs) are serious complications of coronary artery bypass graft (CABG) procedures. It is unclear whether the use of bilateral versus single internal mammary artery (BIMA vs SIMA) and surgical approach to internal mammary artery (IMA) harvest (pedicled vs skeletonized) are independent risk factors for SSI. The use of BIMA grafting redirects blood flow away from the sternum to the heart and may increase SSI risk due to lower tissue perfusion. A skeletonized approach to graft harvest, wherein the IMA is dissected free of surrounding tissue to preserve collateral sternal blood flow, may decrease SSI risk as compared to a pedicled approach in which the IMA is mobilized within a tissue pedicle. We describe the incidence and potential risk factors for post-CABG SSI in an academic tertiary-care center performing ~500 IMA procedures annually. **Methods:** Data were abstracted on adult patients who underwent a CABG procedure using at least 1 IMA graft

Table 1: Changes in Post-CABG SSI Incidence and Surgical Technique, 2017-2020

Time Period	Total # CABG Procedures	Overall SSI/100 procedures	Surgical Approach n (%)		CABG type n (%)	
			Skeletonized	Pedicled	SIMA	BIMA
Jul 17 – Jun 18	550	1.8	160 (29.1)	390 (70.9)	426 (77.5)	124 (22.5)
Jul 18 – Jun 19	561	1.1	192 (34.2)	369 (65.8)	427 (76.1)	134 (23.9)
Jul 19 – Jun 20	480	0.63	189 (39.4)	291 (60.6)	391 (81.5)	89 (18.5)

CABG=coronary artery bypass graft, SSI=surgical site infection, SIMA=single internal mammary artery, BIMA=bilateral internal mammary artery