Methods. As part of an antimicrobial stewardship program (ASP) initiative managing Infectious Diseases consultation for episodes of SAB, our ASP prospectively monitored all cases of SAB at a 341-bed community hospital in Jefferson Hills, PA from April 2017–February 2019. Cases included patients with 30-day mortality from the initial positive blood culture. Only the first episode of SAB was included; patients were excluded if a treatment plan was not established (e.g., left against medical advice). Patient demographics, comorbidities, laboratory results, and clinical management of SAB were evaluated. Inferential statistics were used to analyze risk factors associated with 30-day mortality.

Results. 100 patients with SAB were included; 18 (18%) experienced 30-day mortality. Cases were older (median age 76.5 vs. 64 years, P < 0.001), more likely to be located in the intensive care unit (ICU) at time of ASP review (55.6% vs. 30.5%, P = 0.043), and less likely to have initial blood cultures obtained in the emergency department (ED) (38.9% vs. 80.5%, P < 0.001). Variables associated with significantly higher odds for 30-day mortality in univariate analysis: older age, location in ICU at time of ASP review, initial blood cultures obtained at a location other than the ED, and total Charlson Comorbidity Index (CCI). Variables with P < 0.2 on univariate analysis were evaluated via multivariate logistic regression (Table 1).

Conclusion. Results show that bacteremia due to MRSA and total CCI were not significantly associated with 30-day mortality in SAB, whereas older age was identified as a risk factor. Patients with initial blood cultures obtained at a location other than the ED were at increased odds for 30-day mortality on univariate analysis, which may raise concern for delayed diagnosis.

Disclosures. All authors: No reported disclosures.

173. Successful Treatment of Carbapenem-Resistant Klebsiella pneumoniae (CR-Kp) Aortic Valve Endocarditis with Ceftazidime–Avibactam
Jason V. Alegro, PharmD, BCIDP, BCPS1; Sarah Argentine, NP2; and Lisa Russell, MD1
1Mount Sinai Hospital, Bartlett, Illinois; 2Sinai Health System, Chicago, Illinois

Session: 57. Bacteremia, CLABSI, and Endovascular Infections
Thursday, October 3, 2019: 12:15 PM

Background. The emergence of carbapenem-resistant Klebsiella pneumoniae (CR-Kp) presents significant clinical challenges with our limited antibiotic armamentarium. Infective endocarditis caused by CR-Kp is rare, with few cases reported in the literature. The use of the novel β-lactam/β-lactamase inhibitor combination ceftazidime–avibactam (CAZ-AVI) in this setting has only been described in one 2018 case study. Efficacy and outcomes in patients infected with CR-Kp are limited. The current study represents the first known case of successful treatment of aortic valve endocarditis with CAZ-AVI.

Methods. A 51-year-old male with a past medical history of a gunshot wound to the neck, type 2 diabetes, and osteomyelitis status post right below-the-knee and left toe amputations presented to the emergency department with altered mental status and right upper extremity weakness. The patient’s hospital course was complicated by hemorrhagic stroke, left above-the-knee amputation, and intraoperative cardiac arrest. Subsequently, blood cultures on hospital days 41 and 43 grew CR-Kp and a transesophageal echocardiogram (TEE) showed moderate to severe aortic regurgitation.

Results. Antimicrobial therapy was changed from imipenem-cilastatin and colistin to CAZ-AVI and amikacin. The organism was found to be susceptible to CAZ-AVI and amikacin, intermediate to colistin, and resistant to all carbapenems. A transesophageal echocardiogram (TEE) confirmed the presence of a small mobile vegetation on the aortic valve with perforation and severe regurgitation. CAZ-AVI and amikacin were continued for two weeks, and then switched to CAZ-AVI and ertapenem for four weeks. Nineteen patients (83%) on IV received PO antibiotics after 17 patients (61%) remained on chronic suppression antibiotics (13 PO, 2 IV, 2 PO and IV). Twenty-six (90%) patients had I&D, 6 (21%) had device replacement and 11 (38%) had transplant. Of 21 patients with infection, 16 (76%) had CAZ drainage of pump pocket site or median sternotomy site for a median of 116 days (range 10–887 days). Of 21 patients with peri driveline infections, 6 (29%) had antibiotic impregnated heel beads. Overall survival at 90 days was 28/29 (95%) and 24/29 (83%) at 1 year. Infection-related mortality in Table 1.

Table 1. Multivariate analysis of variables associated with 30-day mortality

| Exposure variable | OR (95% CI) | p-value |
|-------------------|-------------|---------|
| Age               | 1.1 (1.03–1.16) | 0.001 |
| Total CCI         | 1.1 (0.89–1.33) | 0.412 |

Disclosures. All authors: No reported disclosures.

175. There Was a Fungus Among Us: A Cohort of Fungal Infectious Endocarditis Cases in East Tennessee
Morgan K. Morelli, MD1; William Lorson, DO2; and Mahmoud Shorman, MD3
1University of Tennessee Graduate School of Medicine, Knoxville, Tennessee; 2University of Tennessee, Knoxville, Tennessee

Session: 37. Bacteremia, CLABSI, and Endovascular Infections
Thursday, October 3, 2019: 12:15 PM

Background. Fungal infective endocarditis (IE) represents less than 2% of all IE cases, but it carries a mortality rate as high as 50%. While cases of IE are on the rise in recent years due to the increased prevalence of patients who inject drugs (PWID), there are few published studies of fungus as the cause. Candida species is the most likely fungal pathogen in IE. Known risk factors include prosthetic heart valves, healthcare-associated infections, and injection drug use. Since fungi are a rare culprit in endocarditis, there is little information on incidence, treatment recommendations, and outcomes.

Methods. A retrospective cohort of patients with Candida IE was analyzed between October 2013 and September 2018 at a university hospital in East Tennessee. Demographic, microbiologic, substance use status, mortality, and echocardiographic data were collected.

Results. Nine patients with Candida IE met inclusion criteria. Mean age was 37, 67% were males. Risk factors included PWID, oral opioid abuse, previous valve surgery and autoimmune disease. 5 (55%) were caused by Candida albicans, 3 (33.3%) Candida parapsilosis, and 1 (11%) grew both Candida tropicalis and albicans. Valves involved: 4 (66.7%) native tricuspid, 2 (33.3%) native aortic. 2 (22%) had native mitral, 1 (11%) had tricuspid and mitral valve involvement. Echinocandins were used in 5 (55%) and 2 (22%) underwent surgery. There was 1 (11%) in-hospital mortality and 2 (22%) within 1 year of discharge (Table 1).

| Infection site with/without surgical complicating measures | 30-day mortality | 1-year mortality |
|----------------------------------------------------------|-----------------|-----------------|
| Pump infection with chronic chest tube drainage           | 1/6 (60%)       | 3/6 (50%)       |
| Pump infection without chronic chest tube drainage       | 0/5             | 1/5             |
| Driveline infection with antibiotic impregnated bead     | 0/0             | 0/0             |
| Driveline infection without antibiotic impregnated bead  | 0/15            | 1/15            |

Overall: 2/29 (9%) and 5/29 (17%)

Disclosures. All authors: No reported disclosures.

S110 • OFID 2019:6 (Suppl 2) • Poster Abstracts