SCT, including readmissions for sepsis and number of days of antibiotics therapy, was assessed. Controls were matched for time and type of SCT in a three controls to one case ratio. T-test was performed to analyze differences between groups (statistical significance attributed when P = 0.05).

**Results.** The case sample had 20 SCT CPE-positive patients, of which allograft (n = 9) and autograft (n = 11) cases were included. The control sample was made up of 59 SCT CPE-negative patients, allograft (n = 27), and autograft (n = 32). All patients had antibiotic therapy post SCT. Average LOS for the case sample was significantly longer in the autograft group (41.7 vs. 23.6 days, case vs. control, P = 0.01), but not significant in the allograft group (75.1 vs. 58 days, case vs. control, P = 0.12). Both autograft and allograft case samples had significantly longer duration of meropenem therapy, 24.8 vs. 14.4 days for autograft (P = 0.03) and 9.4 vs. 5.5 days for autograft (P = 0.03), cases vs. control. Colistin therapy was longer in both case samples (P = 0.03 in autograft and P = 0.006 in allograft). Tigecycline therapy was significantly longer in the autograft case vs. control sample (P = 0.006), with teicoplanin and piperacillin/tazobactam therapy significantly longer in the autograft case vs. control sample, P = 0.015 and P = 0.03, respectively.

**Conclusion.** The LoS post SCT and duration of antibiotic therapy were found to be key proaryers of worsening outcomes for CPE-positive patients vs. CPE-negative patients who had undergone SCT. Although reasons for CPE colonization vary, there appears to be an overall negative impact on patient outcomes and increased use of more toxic agents, demonstrating the need for early directed CPE decontamination therapy in patients. The use of Faecal Microbiota Transplant (FMT).

**Disclosures.** All authors: No reported disclosures.

**117. Travel-Associated Multidrug-Resistant Organism Acquisition and Risk Factors Among US Military Personnel**

**Background.** Gregory Buchek, MD 1 2; Katrin Mende, PhD 1; Kalyani Telu, MS 3; Susan J. Kaiser, BS 4 5; David R. Trumble, MD, DPhi 1; Jamie Fraser, MPH 1 2; Indranil Mitra, MS 3 6; Tahani Alnani, MBBS, MHS 7; and Heather Yim, MD, FIDSA 1 8. One hundred ten trips were planned by 99 travelers (74% male, median age 38 years [IQR 31, 47.25]); 72 trips were completed by 64 travelers. Median trip duration was 21 days (IQR 12.75, 79.75). Of those with trips completed, 17% traveled to multiple countries. Risk factors for colonization with MDR bacteria in US military personnel traveling internationally for official duty.

**Methods.** TravMil is a prospective observational study enrolling subjects presenting to military travel clinics. We analyzed surveys, antimicrobial use data, and pre- and post-travel self-collected perirectal swabs in military travelers to regions outside the continental United States, Canada, Western Europe, or Northern Europe, or New Zealand presenting to one clinic from December 2015 to December 2017. Gram-negative isolates recovered from swabs underwent real-time identification and susceptibility testing (BD Phoenix).

**Results.** Characteristics of trip and traveler were analyzed to determine risk factors for MDR organism colonization.

**Conclusion.** International travel is a risk factor for incident colonization with extended spectrum β-lactamase (ESBL)-producing organisms. These and other multidrug-resistant (MDR) bacteria are major pathogens in combat casualties. We evaluated risk factors for acquisition of MDR bacteria in US military personnel traveling internationally for official duty. No reported disclosures.

**117. A Cluster of Carbapenemase-Producing Acinetobacter baumannii**

**Background.** Heather Young, MD 1; Caroline Croyle, MPH 2; Sarah J. Janell, MPH, CIC 3; Bryan Kuepper, MPH, MS, CIC 4; Jennifer Kurtz, BSN 5; Amber Miller, MSN, RN, CRN 6; CISPDT 7; Sara Reese, PhD, MPH, CIC, TAPC 5; Kyle Schutz, MPH 5 and Wendy Bamberg, MD 1; Infectious Diseases, Denver Health Medical Center, Denver, Colorado; 2Patient Safety and Quality, Denver Health Medical Center, Denver, Colorado; 3Colorado Department of Public Health and Environment, Denver, Colorado.

**Methods.** Carapenem-resistant A. baumannii (CRAB) is reportable in Colorado and the hospital and the Colorado Department of Public Health and Environment (CDPHE) conducted an investigation to determine epidemiologic links and molecular relatedness of the isolates.

**Results.** We reviewed medical records and performed infection control observa- tions among staff. Pulsed field gel electrophoresis (PFGE) was performed at CDPHE; antimicrobial susceptibility (AST) and carbapenemase testing was performed at CDC.

**Conclusion.** Epidemiologic investigation: Both patients had neurogenic bladders managed by suprapubic catheters, stage IV decubitus ulcers, and recent surgery. Neither had traveled outside of Colorado. Although both received recent antibiotics, neither received a carbapenem in the 6 previous months. Both isolates were regarded to be asymptomatic bacteriuria. In November 2017, the patients overlapped for 7 days at DHMC on different units. During this week, the same nurse provided wound care for both patients on the same day. Observations of the wound care team revealed oppor- tunities to improve hand hygiene prior to donning and after doffing gloves, the use of single-use scissors on multiple patients, and inconsistent cleaning of a mobile device used to photograph wounds. Microbiologic and molecular investigations: Isolates from the two patients were indistinguishable by PFGE. AST found both isolates susceptible to colistin, but resistant to all other antimicrobials tested (Table 1); both harbored OXA-23-like genes by a Research Use Only assay performed at CDC.

**Disclosure.** These are the first carbapenemase-producing A. baumannii strains identified in Colorado. We suspect that they were transmitted during the overlapping hospital admission, although we could not determine where the organism originated or the route of transmission. Opportunities to improve hand hygiene and low-level disinfection were identified. The emergence of previously undetectable carbapenemases in Colorado is of great public health concern; collaboration between public health and healthcare facilities is critical to halt transmission of novel regional pathogens.

**Disclosures.** All authors: No reported disclosures.

**1174. Epidemicity of Carbapenem-Resistant Enterobacteriaceae, a 5-Year Experience at a Tertiary Care Hospital**

**Background.** Darunee Chotiprasitsukool, MD, MPH 1; Sirawat Srichatrapimuk, MD, PhD 2; Suppachok Kirdarp, MD 3; and Pitak Santinantirat, PhD 2; 1Department of Medicine, Faculty of Medicine Ramathibodi Hospital, Mahidol University, Bangkok, Thailand; 2Chakri Naruebodindra Medical Institute, Faculty of Medicine Ramathibodi Hospital, Mahidol University, Samutprakan, Thailand; 3Department of Pathology, Faculty of Medicine Ramathibodi Hospital, Mahidol University, Bangkok, Thailand.

**Disclosures.** All authors: No reported disclosures.

**1175. A Cluster of Carbapenemase-Producing Acinetobacter baumannii**

**Background.** Carapenem-resistant Enterobacteriaceae (CRE) has been increasing worldwide. Our objectives were to study the epidemicology of CRE and compare risk factors and mortality of carbapenem non-susceptibility to etrapenem alone Enterobacteriaceae (NSEE) with nonsusceptibility to other carbapenems (imipenem, meropenem, or doripenem) Enterobacteriaceae (NSEOCE) at a tertiary care hospital in Thailand.

**Methods.** All CRE isolated from clinical and surveillance cultures were identified from December 2011 to December 2016. Quarterly incidence rate per 100,000 patient-days was estimated. Hospital-wide carbapenem consumption were calculated as defined daily doses (DDD) per 1,000 patient-days. Relationships between hospital-wide carbapenem consumption and incidence of CRE were tested using Poisson regression. Comparative analysis of factors associated with NSEE and NSEOCE, and risk factors associated with 14- and 30-day mortality in patients with CRE infection was conducted in adult patients.

**Results.** The quarterly CRE incidence of unique patients increased significantly from 3.3 per 100,000 patient-days in the last quarter of 2011 to 32.49 per 100,000 patient-days in the last quarter of 2016. Quarterly CRE incidence increased 1.07 per 100,000 patient-days (95% CI, 0.49–1.66; P-value for trend <0.001). Quarterly hospital-wide carbapenem consumption increased 1.58 DDD per 1,000 patient-days (95% CI, 0.14–1.00; P-value for trend = 0.04). The expected increase of CRE incidence was 1.02 per 100,000 patient-days for a one DDD per 1,000