**1104. Safety and Efficacy of Telavancin at an Outpatient Parenteral Antibiotic Therapy (OPAT) Unit in New York City**

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**Session:** 141. Clinical Practice Issues

**Friday, October 6, 2017: 12:30 PM**

**Background.**  Telavancin is an intravenous (IV) lipoglycopeptide with concentration-dependent bactericidal activity against a broad spectrum of gram-positive organisms and is approved for the treatment of skin and structure infections and nosocomial pneumonia; however, post-marketing data is limited. At a hospital-based Outpatient Parenteral Antibiotic Therapy (OPAT) unit, telavancin is used to treat patients due to its convenient daily dosing, its lack of need for therapeutic drug monitoring and its potent in-vitro gram-positive activity. We sought to evaluate the safety and efficacy of telavancin in the OPAT setting.

**Methods.**  We performed a two-year, IRB-approved, retrospective evaluation of all adult patients admitted to the OPAT unit treated with telavancin. Primary outcome was clinical success defined as completion of telavancin and documented clinical resolution. Secondary outcomes included time to initial clinical improvement, 30-day infection-related readmission, frequency and time to acute kidney injury (AKI) per RIFLE criteria and incidence of adverse drug reactions (ADRs).

**Results.**  A total of 43 patients were evaluated. Median age was 51 years, 56% were male, and 84% were admitted from the hospital. Baseline demographics differed between clinical failure and success in BMI (38.1 vs. 31.0; P = 0.148) and chronic vascular insufficiency (33% vs. 11%; P = 0.196). AKI occurred in 4.7% of all patients, (7.1% (n = 2/28); P = 0.02). 30-day infection-related readmission was observed (0% vs. 37%; P = 0.37). No difference in time to acute kidney injury (0 vs. 7 days; P = 0.5).

**Conclusion.**  Our study shows real-life experience with telavancin in an OPAT setting, demonstrating tolerability, efficacy, and potential factors which may predispose one to clinical failure (BMI, vascular insufficiency, and dosing). Further investigation is warranted to better individualize patient selection and optimize dosing and management of ADRs.

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

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**1105. To Add or Not to Add: Would the Addition of Dalbavancin to Formulary Decrease Admissions for Acute Bacterial Skin and Skin Structure Infections (ABSSSI)?**

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**Session:** 141. Clinical Practice Issues

**Friday, October 6, 2017: 12:30 PM**

**Background.**  One of the major advantages of dalbavancin is that it may be administered as a single dose for the treatment of acute bacterial skin and structure infections (ABSSSI). Our objective was to determine the number (%) of patients with an ABSSSI diagnosis whose admission to a county hospital could have been avoided if dalbavancin was on formulary.

**Methods.**  From November 2016 to April 2017, we reviewed encounters for adult patients seen in the emergency department or inpatient setting with a primary ABSSSI admission diagnosis. For those admitted, potential candidates for dalbavancin included those with ≥2 local signs/symptoms of ABSSSI AND ≥1 systemic sign of infection AND none of the exclusion criteria used in the DISCOVER 1 and 2 trials.

**Results.**  An estimated 91% of patients with ABSSSI would have met the criteria for dalbavancin. For those admitted, potential candidates for dalbavancin included those with <2 local signs/symptoms of ABSSSI AND ≥1 systemic sign of infection AND none of the exclusion criteria used in the DISCOVER 1 and 2 trials. Potential candidates were classified as qualifying for dalbavancin if they received IV antibiotics for ≥3 days but <14 days, had no Gram-negative or anaerobic organisms isolated, had no operative intervention nor ≥2 incision and drainage procedures, had no associated orthopedic fracture, had no history of malnutrition, had no history of infection within 30 days prior to Presenting ABSSSI, and did not require hospitalization for management of other comorbidities.

**Conclusion.**  Our study shows real-life experience with telavancin in an OPAT setting, demonstrating tolerability, efficacy, and potential factors which may predispose one to clinical failure (BMI, vascular insufficiency, and dosing). Further investigation is warranted to better individualize patient selection and optimize dosing and management of ADRs.

**Disclosures.**  All authors: No reported disclosures.
Results. Of 1203 patients with a primary diagnosis of ABSSI, only 219 (18%) were admitted, of whom only 11 (5%) were classified as potential candidates for dalbavancin. The most common reasons admitted patients were excluded as potential candidates were not meeting signs and symptoms criteria (n = 147), age <18 years (n = 13), being admitted to the hospital for >14 days (n = 11), periorbital or joint cellulitis (n = 9), deep seated infection (n = 5), required admission for another reason (n = 5), and diabetic foot ulcer (n = 4). Of the 11 potential candidates, one qualified for dalbavancin based on our criteria.

Conclusion. At our hospital, only a minority of patients with a primary diagnosis of ABSSI were treated with dalbavancin, and one ultimately met our criteria for dalbavancin use. Adding dalbavancin to our formulary would not have resulted in fewer admissions for patients with ABSSI.

Disclosures. All authors: No reported disclosures.

1106. Is There a Significant Difference in Acute Kidney Injury Incidence Among Patients Treated with Memantine Combined with FEP+V AN 10.8% vs. FEP+V AN.

Methods. Demographic and clinical data were abstracted from the University of Kentucky Center for Clinical and Translational Sciences Enterprise Data Trust from 2008 through 2015. Patients were included if they received V AN and FEP or MEM in combination for ≥48 hours. Patients with baseline CKD and creatinine clearance <30 mL/min were excluded. AKI was defined using any of the Risk, Injury, Failure, Loss, End-stage (RIFLE) criteria. Basic descriptive statistics were performed in addition to bivariable and multivariable logistic regression for AKI.

Results. In total, 3662 patients were included in this study with 3366 patients receiving FEP+V AN and 296 patients receiving MEM+V AN. Demographic characteristics were evenly distributed among both groups, with the exception of Charlson comorbidity index (MEM+V AN 4 [2–6] vs. 3 [1–6], P = 0.0002), and exposure to aminoglycosides (MEM+V AN 18.2% vs. 13.2%, P = 0.02) and calcineurin inhibitors (MEM+V AN 6.1% vs. 3.7%, P = 0.03). Otherwise, incidence was similar between group (MEM+V AN 12.8% vs. FEP+V AN 10.8%, P = 0.33). After multivariable logistic regression, there was no significant increase in AKI odds with MEM+V AN compared with FEP+V AN adjusted odds ratio = 1.10; 95% CI 0.67–1.81). Factors associated with increased AKI odds included: male gender, increased baseline comorbidity, age ≥80, increased duration of antimicrobial therapy, hypotension, increased baseline renal function, and exposure to aminoglycosides, amphotericin B, non-steroidal anti-inflammatory drugs, loop diuretics, or vasopressors.

Conclusion. No difference in AKI incidence was found between patients treated with MEM+V AN vs. FEP+V AN. Other clinical factors aside from AKI potential should be considered when choosing between alternatives to piperacillin-tazobactam combined with vancomycin.

Disclosures. All authors: No reported disclosures.

1107. Pharmacist-Directed Use of Dalbavancin in Acute Bacterial Skin and Skin Structure Infections to Reduce Hospital Length of Stay

Methods. As no further requirement for IV vancomycin on the last day of therapy with either oral step down therapy or no further antibiotic.

Results. Fifty-four patients were identified who received dalbavancin during the enrollment period, and 44 were included in the study. In the comparator group 1191 patients were identified that 945 were included in the study. Hospital LOS (4.3 vs. 3.7, P < 0.001) and total direct cost per case ($7,863 vs. $2,989, P < 0.001) were statistically significantly decreased for the dalbavancin group compared with the comparator group. Readmission rates at 30 days were similar between the dalbavancin and comparator groups (11.4% vs. 8.6%, P = 0.34).

Conclusion. Patients discharged to an outpatient infusion center to receive dalbavancin had a decreased LOS and total direct cost per case in relation to the comparator group. No statistical difference was observed in 30 days of discharge. Early goal-directed discharge for the treatment of patients with ABSSI is a safe and effective way to decrease LOS.

Disclosures. B. Jones, Allergan: Speaker's Bureau, Speaker honorarium.