were drawn from individuals on RRT, and 32/80 were in a IS individuals. From 3/2020-3/2021, 45/107 cultures were drawn from an individual on ECMO, 24/107 were drawn in an individual on RRT, and 73/107 were drawn in a IS individuals. The majority of individuals in whom a fungal blood culture was drawn during 3/2020-3/2021 were individuals with COVID-19. Upon chart review most of the cultures were drawn due to concern for candidemia.

Results. Fungal blood cultures drawn from 3/2019-3/2021 at OHSU.

Conclusion. Fungal blood cultures have an extremely low yield at our institution, with a 1.6% positivity rate over a 2 year period, and all of those cultures were detected by standard blood culture isolators. Most of these cultures were drawn in situations where this test has no utility. Furthermore, the test has limited utility to detect dimorphic and mold bloodstream infections. Restriction of this test may limit situations where this test has no utility. Furthermore, the test has limited utility to detect dimorphic and mold bloodstream infections. Restriction of this test may limit appropriacy of infections.

Disclosures. All Authors: No reported disclosures

76. Uncomplicated Urinary Tract Infections in the Multi-resistance Era: Is It Time of Microbiologic Diagnosis? An Observational Study in Buenos Aires City

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Uncomplicated urinary tract infection (uUTI) is one of the main causes of antibiotics prescription in outpatient setting. Current recommendations, based on studies from pre-antimicrobial resistance era, suggest that diagnosis of uUTI can be made based on clinical symptoms and that urine analysis leads only to a minimal contribution to diagnostic accuracy. We analyzed urinary cultures (UC) from patients with clinical diagnosis.

Methods. Prospective and observational study carried out in an Emergency Department during August 2016 to August 2017. Women older than 15 years with 2 or more classic symptoms of uUTI and the absence of vaginal discharge and irritative symptoms were included. Those with complicated and recurrent urinary tract infection (UTI) were excluded. Urine cytology and UC were performed in all episodes. A bivariate and multivariate analysis was performed considering the probability of having a positive urine culture according to the different symptomatology variables.

Results. We enrolled 208 patients, with a median age of 25 (14-68 years). Previous UTI 6 (2.9%), previous antibiotic (last 3 months) 20 (9.6%), Inflammatory cytology 173 (83.2%), positive UC 109 (52.4%), cystitis 155 (74.5%). Symptoms: dysuria 154 (74%), frequency 111 (53.4%), tenesmus 97 (46.6%), fever 78 (37.5%), hematuria 43 (20.7%), hypogastric pain 128 (61.5%), back pain 84 (40.4%). Combinations of > 2 symptoms occurred 154 (74%), frequency 111 (53.4%), tenesmus 97 (46.6%), fever 78 (37.5%), hematuria 43 (20.7%), hypogastric pain 128 (61.5%), back pain 84 (40.4%).

Table 1: Bivariate analysis for symptoms associated urine culture positive

| Symptoms                  | Negative n (%) | Positive n (%) | p     | OR IC (95%) |
|---------------------------|----------------|----------------|-------|-------------|
| Dysuria                   | 70 (45.5)      | 84 (54.5)      | 0.296 | 0.849 (0.615-1.598) |
| Frequency                 | 48 (43.2)      | 63 (56.8)      | 0.179 | 0.838 (0.641-1.086) |
| Tenesmus                  | 51 (52.6)      | 46 (47.4)      | 0.179 | 1.197 (0.918-1.560) |
| Fever                     | 33 (42.3)      | 45 (57.7)      | 0.237 | 0.853 (0.659-1.105) |
| Hematuria                 | 23 (53.5)      | 20 (46.5)      | 0.385 | 1.16 (0.817-1.646)  |
| Hypogastric pain          | 64 (50)        | 64 (50)        | 0.380 | 1.125 (0.868-1.458) |
| Back pain                 | 39 (46.4)      | 45 (53.6)      | 0.781 | 0.963 (0.741-1.252) |
| Combination of >3 symptoms| 27 (51.9)      | 25 (48.1)      | 0.936 | 0.974 (0.519-1.826) |

Table 2: Multivariate analysis for symptoms associated urine culture positive

| Symptoms                  | p     | OR IC (95%) |
|---------------------------|-------|-------------|
| Dysuria                   | 0.155 | 0.568 (0.260-1.238) |
| Frequency                 | 0.166 | 0.659 (0.365-1.189) |
| Tenesmus                  | 0.118 | 1.588 (0.889-2.837) |
| Fever                     | 0.270 | 0.706 (0.380-1.310) |
| Hematuria                 | 0.654 | 1.174 (0.582-2.368) |
| Hypogastric pain          | 0.604 | 1.170 (0.647-2.116) |
| Back pain                 | 0.342 | 0.719 (0.364-1.420) |
| Combination of >3 symptoms| 0.687 | 0.79 (0.264-2.402)  |

Conclusion. The results show that almost 50% of the patients with a clinical diagnosis of UTI had a negative urine culture. We consider it necessary to rethink the prescription of antibiotics without microbiological confirmation in the first episode of UTI as a strategy to reduce inappropriate use of antibiotics.

Disclosures. All Authors: No reported disclosures

77. Opportunity for Improved Use of a Commercially Available Meningitis/Encephalitis Panel in Pediatric Patients

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Session: P-05. Antimicrobial Stewardship: Diagnostics/Diagnostic Stewardship

Background. The BioFire FilmArray Meningitis/Encephalitis (ME) panel delivers timely CSF analysis when meningitis or encephalitis is suspected and has the potential for earlier optimization of patient care. It is unclear if the M/E panel provides incremental benefit over standard microbiologic methods such as culture and cell counts, especially in the absence of significant pleocytosis. We evaluated the clinical utility of the ME panel with respect to CSF white blood cell count per high power field (WBC/hpf) and patient age.

Methods. We identified paired CSF ME panels and CSF cultures collected throughout a large healthcare system from 2016–May 2021 in children < 18 years of age. CSF results from the same calendar day were included in the dataset. We reviewed standalone HSV and Enterovirus (EV) CSF studies to determine frequency of duplicative testing. Results were stratified by CSF WBC/hpf and patient age (< 14 days, 14–60 days, > 60 days and < 5 years, and > 5 years).

Results. 1045 paired cultures and ME panels were identified. Of those, 921 (88%) ME panels were negative, but 5 of those cultures grew bacteria. Of 124 (12%) positive ME panel results, 66% were viral: 46 (37%) EV, 22 (18%) HHV-6 and 6 (5%) parechovirus. In 498 cases, ME panels were sent when CSF had < 10 WBC/hpf, resulting in only 2 (0.4%) PCRs positive for bacteria, one which was gram stain positive and the other was considered a false positive. In addition to a ME panel, standalone PCRs for enterovirus and HSV were sent in 134 (13%) and 213 (20%) of cases, respectively, with < 2% discordance. Pathogen distribution by ME panel did not vary with age (Table 2).

Table 1. Meningitis and encephalitis panel results by CSF white blood cell count

| Organism          | Unknown | 30 or less WBC | >30 WBC | Greater 10 – 50 WBC | Greater 50 WBC |
|-------------------|---------|----------------|---------|---------------------|----------------|
| Escherichia coli K1 | 1       | 0              | 1       | 2                   |                |
| Group B Streptococcus | 1     | 1              | 0       | 9                   |                |
| Haemophilus influenzae | 0   | 1              | 1       | 10                  |                |
| Neisseria meningitidis | 0    | 0              | 0       | 2                   |                |
| Streptococcus pneumoniae | 3   | 0              | 2       | 2                   |                |
| Enterovirus | 1      | 7              | 7       | 31                  |                |
| Human Herpes Virus 6 | 0     | 13             | 5       | 4                   |                |
| Human Parechovirus | 1      | 4              | 1       | 0                   |                |
| Herpes Simplex Virus 1 | 0   | 0              | 0       | 1                   |                |
| Herpes Simplex Virus 2 | 0   | 0              | 0       | 2                   |                |
| Varicella | 0      | 0              | 0       | 4                   |                |
| Cytopherugovirus | 1      | 0              | 0       | 0                   |                |

The results show that almost 50% of the patients with a clinical diagnosis of UTI had a negative urine culture. We consider it necessary to rethink the prescription of antibiotics without microbiological confirmation in the first episode of UTI as a strategy to reduce inappropriate use of antibiotics.

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