of the T2 and BC in Tx and non-Tx patients were compared. BC obtained within 7 days before or after the T2 test were included in the analysis. TAT, sensitivity, specificity, PPV and NPV were calculated using positive BC as the standard. Differences between groups were assessed using two sample proportions testing at α = 0.05.

Results. A total of 1,272 patients with suspected candidemia had T2 done: 1,162 (91%) non-Tx and 110 (9%) Tx patients. Average TAT for T2 was 13 hours (5–41) vs. 34 hours (21–109) to initial positive BC result and 4 days (3–13) to species-specific BC result. In four non-Tx patients with negative T2, C. lusitaniae and C. dubliniensis and C. kefyr were isolated in BC. Performance characteristics of T2 and BC in the two groups are shown (Table 1). Of the 12 T2/BC- cases (n = 103), 9% had retinitis and 9% had invasive candidiasis.

Conclusion. The rapid TAT, good sensitivity, and high NPV of T2 in Tx patients has clinical implications and can help support antifungal stewardship efforts in this population. The clinical significance of T2 positivity in the presence of negative BC needs further investigation.

Table 1: Performance Characteristics of T2 Compared with BC (N= 1,272)

|        | T2 (n = 110) | Non-Tx (n = 1162) | P-value |
|--------|--------------|-------------------|---------|
| T2 + and blood culture + | 5 (4.5%) | 35 (3.0%) | 0.3917 |
| T2 + and blood culture – | 19 (17.3%) | 86 (7.4%) | 0.0003 |
| T2 - and blood culture + | 1 (0.9%) | 41 (3.5%) | 0.1431 |
| Sensitivity | 83.3% | 46.1% | |
| Specificity | 91.9% | 92.4% | |
| PPV | 20.8% | 28.9% | |
| NPV | 98.8% | 96.2% | |

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113. Strongyloides Stercolaris Serology in Transplant Patients: To Test or Not? Karla Rivera Rivera, MD; Tulsi Shah, MBBS; Julia Garcia-Diaz, MD, FIDSA and Jonathan Hand, MD.

Invasive aspergillosis (IA) is a significant complication status post transplantation with significant morbidity and mortality. Treatment for Strongyloides stercoralis can lead to hyperinfection and dissemination after transplantation with significant morbidity and mortality. Treatment for Strongyloides prior to transplantation can reduce the risk of disseminated infection. Targeted screening based on travel history and country of origin incompletely identifies at-risk patients. Data on universal screening prior to solid-organ (SOT) or hematopoietic stem cell transplantation (HSCT) are limited. We implemented universal serology-based screening for Strongyloides at our transplant center, located in a metropolitan non- endemic area.

Methods. We identified patients screened with Strongyloides IgG by ELISA during pre-transplant evaluation for SOT or HSCT from August 1, 2017 to April 25, 2018. We reviewed adherence to the screening recommendation by program type and the medical record of seropositive patients for country of origin, history of eosinophilia (>500 cell/μL), Gram-negative bacteremia, ova and parasite (O&P) examination and treatment.

Results. A total of 812 patients were evaluated for transplant during the study period: 484 for kidney, 152 for liver, 12 for liver/kidney transplant, 40 for heart, 24 for lung, and 100 for HSCT. 201 (24.7%) of the 812 patients were screened for Strongyloides; 107 (17%) evaluated for abdominal transplant, 32 (50%) for thoracic transplant, and 2 (2%) for HSCT. Seventeen (8.4%) of 201 patients screened tested positive: nine evaluated for kidney transplant, four for heart, one for liver, and three for HSCT. Nine of 17 patients (53%) were treated with Ivermectin or referred to Infectious Disease. Six patients (15%) were treated with Ivermectin and referred to Infectious Disease from countries other than the United States; and one from Puerto Rico. Two patients with Strongyloides had eosinophilia, one had history of Klebsiella pneumoniae bacteremia and one had stool O&P examination. Screening was higher when using an electronic order set (57% vs. 12%).

Conclusion. Universal screening for Strongyloides identified individuals with latent infection who did not have epidemiological or clinical findings suggestive of Strongyloides. Screening for Strongyloides was higher in transplant programs that incorporated the recommendation into an electronic order set.

Disclosures. All authors: No reported disclosures.

113. Implementation of Universal Screening for Strongyloides Among Solid-Organ and Hematopoietic Stem Cell Transplantation Candidates in a Non-endemic Area

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Session: 134. Fungi and Parasites in Immunocompromised Patients Friday, October 5, 2018: 12:30 PM

Background. Strongyloides can lead to hyperinfection and disseminated disease after transplantation with significant morbidity and mortality. Treatment for Strongyloides prior to transplantation can reduce the risk of disseminated infection. Targeted screening based on travel history and country of origin incompletely identifies at-risk patients. Data on universal screening prior to solid-organ (SOT) or hematopoietic stem cell transplantation (HSCT) are limited. We implemented universal serology-based screening for Strongyloides at our transplant center, located in a metropolitan non- endemic area.

Methods. We identified patients screened with Strongyloides IgG by ELISA during pre-transplant evaluation for SOT or HSCT from August 1, 2017 to April 25, 2018. We reviewed adherence to the screening recommendation by program type and the medical record of seropositive patients for country of origin, history of eosinophilia (>500 cell/μL), Gram-negative bacteremia, ova and parasite (O&P) examination and treatment.

Results. A total of 812 patients were evaluated for transplant during the study period: 484 for kidney, 152 for liver, 12 for liver/kidney transplant, 40 for heart, 24 for lung, and 100 for HSCT. 201 (24.7%) of the 812 patients were screened for Strongyloides; 107 (17%) evaluated for abdominal transplant, 32 (50%) for thoracic transplant, and 2 (2%) for HSCT. Seventeen (8.4%) of 201 patients screened tested positive: nine evaluated for kidney transplant, four for heart, one for liver, and three for HSCT. Nine of 17 patients (53%) were treated with Ivermectin or referred to Infectious Disease. Six patients (15%) were treated with Ivermectin and referred to Infectious Disease from countries other than the United States; and one from Puerto Rico. Two patients with Strongyloides had eosinophilia, one had history of Klebsiella pneumoniae bacteremia and one had stool O&P examination. Screening was higher when using an electronic order set (57% vs. 12%).

Conclusion. Universal screening for Strongyloides identified individuals with latent infection who did not have epidemiological or clinical findings suggestive of Strongyloides. Screening for Strongyloides was higher in transplant programs that incorporated the recommendation into an electronic order set.

Disclosures. All authors: No reported disclosures.

113.6. Universal Prophylaxis for Prevention of Invasive Aspergillus in Lung Transplant Recipients

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Background. Invasive aspergillosis (IA) is a significant complication status post lung transplantation with an incidence of 6% to 16%. Because early diagnosis of IA in lung transplant is hampered by the lack of specific clinical signs and by the low sensitivity of culture-based diagnostic methods, the efficacy of bronchoalveolar lavage galactomannan (BAL GM) for early diagnosis is explored in this study.

Methods. A retrospective analysis was performed on 45 consecutive lung transplant recipients between January 2015 and February 2016 at UF Health Shands Hospital. All patients were placed on prophylactic itraconazole post-transplant. Surveillance bronchoscopies were performed at 2 weeks, 1 month, 3 months, 6 months, 9 months, and 12 months post-transplant. During each bronchoscopy, bacterial, fungal, and acid-fast bacterial cultures along with BAL GM (an optical density [OD] index of ≥0.5 considered positive) were obtained. If BAL GM ≥1.0, the patient was switched to voriconazole for further treatment. CT Chest was also evaluated. If BAL GM remained ≥1.0 at the 6 month interval, then prophylaxis was complete. IA was defined using the EORTC/MSG criteria for invasive fungal disease (i.e., patient classified as either having proven, probable or possible IA).

Results. There was a total of 225 observations from the 45 patients. Two patients (4.4%) had proven IA with a mean GM of 4.15 (SE, 0.62) and seven patients (15%) had probable IA with a mean of 2.16 (SE, 0.49). There was no correlation of cold ischemic time (P = 0.86), primary graft dysfunction (P = 0.38), presence of Candida species (P = 0.048) or non-tuberculous mycobacteria (NTM) in bronchoalveolar lavage (P = 0.044), and viral pneumonitis (P = 0.047) with a positive BAL GM. All nine patients with GM >1 were switched to voriconazole from itraconazole which resulted in negative GM levels on follow-up bronchoscopy.

Disclosures. All authors: No reported disclosures.