of piped water in El Salvador is by the ‘Administración Nacional de Acueductos y Alcantarillados’ (ANDA) agency in El Salvador, contracted decentralized operators, and/or non-decentralized operators. Descriptive statistics was done to understand the study population and logistic regression was conducted to determine the association between STTH infection and drinking water supply in the study population.

Results. Of 1310 children, 49.01% (n = 642) were male and 30.46% (n = 399) were 8 year olds. The prevalence of STTH infections in the study population was 2.75% for Ascaris lumbricoides, 4.10% for Trichuris trichiura, and 1.83% for hookworm. Source of drinking water supply was significantly associated with STTH infection in the study population compared with individuals who resided in areas supplied by ANDA, individuals who resided in areas supplied by the decentralized operators under contract management, the risk of infection was 2.8 times higher than amongst those who resided in areas receiving drinking water through piped supply by decentralized operators not under contract management.

Conclusion. Our results show that there is a significant association between the piped drinking water supply and Ascaris lumbricoides infection in the study population.

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288. Community Health Workers Can Strengthen Isoniazid Preventive Therapy Implementation in Rural KwaZulu-Natal, South Africa
Sarah Norton, MA 1; Anthony Moll, MChB 2; Jabullel Madi, Professional Nurse 3; Nkani Nkomo, Social Worker 1; Ralph Brooks, MS 3 and Sheela Shenoi, MD, MPH 4; 1Duke University, Durham, North Carolina, 2Church of Scotland Hospital, Tugela Ferry, KwaZulu-Natal, South Africa, 3Phيلانjo NGO, Tugela Ferry, South Africa, 4Tuleyale University School of Medicine, New Haven, Connecticut
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Background. Tuberculosis (TB) remains one of the top 10 causes of death globally, centrally driven by infection and the drug supply. TB incidence is highest in rural areas of Africa where the WHO highlights isoniazid preventive therapy (IPT) as a major strategy to combat HIV-associated TB. Community health workers (CHWs) have been utilized in the differentiated care models for HIV treatment programs; pilots have shown their efficacy in screening for TB. No studies have evaluated CHW’s role in implementing IPT. This study explores the potential role of CHWs in expanding IPT in rural KwaZulu-Natal, South Africa.
Methods. The study was conducted in the Msinga sub-district where CHWs were provided training in multidisease screening including HIV, TB, hypertension, and diabetes mellitus, and educated on the nuances of IPT eligibility. CHW’s screened up to 30 individuals a month. The primary outcome was the proportion of patients who were HIV (+) and TB (+) who were identified by CHWs as eligible for IPT and subsequently referred for care. The secondary outcomes included the percentage of those referred for IPT that were linked to care and the percent initiated on IPT.
Results. Among 1279 individuals screened for HIV and TB December 2015–September 2016, 213 (16.76%) were HIV positive and had a negative TB symptom screen. Of those, 114 (54.5%) were currently on IPT or had been on IPT in the last 12 months and were thus not eligible for preventive treatment. Of the remaining 99 community members eligible for IPT, CHWs referred 46 (46.5%). For those referred, median age was 39 (IQR 30–48) and 91.3% were female. Of those, 29 (63%) linked to care and 23.9% (29 of those referred and 37.4% of those linked to care) initiated IPT.
Conclusion. In rural areas of KwaZulu-Natal, South Africa, CHW’s have the capacity to not only screen for infectious and chronic disease, but to simultaneously evaluate for prevention opportunities, such as for IPT. Further research exploring barriers to IPT initiation and how to address such roadblocks should be prioritized to inform the role that CHW’s can play in implementing IPT. Future efforts should focus on closing the gaps in the IPT cascade of care in order to maximize the impact of IPT on the TB epidemic.

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289. Frequency of Combination Medications Associated with QTc Prolongation in a Travel Clinic
Judy a Streit, MD 1; and Laura Stullenk, PA 2; 1Division of Infectious Diseases, Department of Internal Medicine, University of Iowa Carver College of Medicine, Iowa City, Iowa, 2Ist Med, University of Iowa, Iowa City, Iowa
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Background. A common practice during a travel medicine clinic visit is to provide an antibiotic prescription for stand-by treatment of moderate-to-severe traveler’s diarrhea. Ciprofloxacin/levofloxacin or azithromycin are often used for this purpose. These antibiotics have been implicated in prolonging the QTc interval. Medication lists of travelers can include non-antibiotic agents that can prolong the QTc interval as well. Hence, situations with cumulative QTc prolongation by multiple agents, with an attendant risk for associated arrhythmia, may be relatively common. They may warrant further risk assessment by the provider, such as obtaining an EKG. We quantified the frequency of potential drug-drug interactions in Travel Clinic patients in a retrospective review of a random 3-month cohort of patients who visited our Travel Clinic in 2016. New oral antibiotics were prescribed. Whether an EKG was recommended by the provider because of perceived cumulative medication-related risk of QTc prolongation was recorded.

Methods. A chart review, including medication lists, occurred for 158 consecutive patients who visited our Travel Clinic in a 3-month period. The number of patients taking specified medications with potential for QTc prolongation at the time of their Travel Clinic visit and the frequency of specific agents were tallied. Whether EKGs were recommended was recorded.
Results. 23/158 travel clinic patients (14.6%) were taking antidepressant medications with at least moderate potential for QTc prolongation when combined with a quinolone or azithromycin. An additional nine patients (5.7%) were prescribed multiple other agents with QTc prolongation potential at the conclusion of their Travel Clinic visit. An EKG for risk assessment was recommended by the Travel Clinic provider for seven patients (4.4%).

Conclusion. Travel Clinic patients often are prescribed medications that may enhance the QTc prolongation potential of antibiotics used for stand-by treatment of traveler’s diarrhea drug-drug interactions that could increase risk for an arrhythmia warrant a careful medication history and risk assessment in the clinic.

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290. Clinical and Epidemiological Characteristics of Japanese Spotted Fever and Scrub Typhus in Central Japan, 2004-2015
Eiichiro Sanda, MD 1; Moton Suzuki, MD 1; Makito Yaegashi, MD 1; Masakatsu Taira, DVM 1; Tomoko Oogawa, DVM, PhD 2 and Koya Areyoshi, MD 1; 1Department of General Internal Medicine, Kameda Medical Center, Kamogawa, Japan, 2Institute of Tropical Medicine, Nagasaki University, Nagasaki, Japan, 3Division of Virology, Chiba Prefectural Institute of Public Health, Chiba, Japan
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Background. Japanese spotted fever (JSF) and scrub typhus (ST) are endemic rickettsial diseases in Japan. Both JSF and ST are caused by Rickettsia japonica and Rickettsia tsutsugamochi, respectively. To date, three studies have comparatively compared JSF with ST, we investigated the clinical and epidemiological characteristics of JSF and ST in the area where both are endemic.
Methods. We systematically collected clinical and epidemiological data from all patients with JSF and ST notified to the National Institute of Infectious Diseases in Boso Peninsula of Japan between 2004 and 2015. Indirect immunofluorescence assays were used, and eschar PCR/immunoperoxidase assays were also used for identifying the strain. SatScan was used for spatial cluster analysis.
Results. In total, 661 patients were enrolled, 44% were female, and the mean age was 64 years. Thirty-two patients were diagnosed as JSF, 204 were ST, and 97 were non-rickettsial diseases. Only one patient died of ST. Comparing to non-rickettsial diseases, patients with JSF and ST were significantly older, and more of them resided in wooded areas (P < 0.001). Spatial clusters were identified for both JSF (P < 0.001) and ST (P < 0.05). JSF occurred from April to October with a small peak in July, while 90.2% of ST was diagnosed in November and December. Both rash and eschar were detected in the majority of JSF (97%, 86%) and ST (96%, 87%). When compared with ST, purpura, and the rash on palms/soles were strongly associated with JSF (OR, 29.0, 6.1, respectively). However, patients were much less likely to complain their rash (27% JSF, 44% ST) and eschar (0% JSF, 2.5% ST). Moreover, 26% of JSF and 28% of ST cases did not present with apparent fever (37.5°C). All identified ST strains were Irie/Kawasaki (16/22, 73%) or Hirano/Kuroki (6/22, 27%).
Conclusion. Although clinical picture of JSF and ST are similar, there are some clues to distinguish JSF from ST such as seasonality, geographical region, rash distribution on palms/soles, and the hemorrhagic nature of rash. Rickettsial cases may be underdiagnosed if clinical diagnosis relies on fever, rash, and eschar.

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291. Clinico-Epidemiological Profile of Adolescent and Adult Patients with Tegumentary Leishmaniasis from the Colombian Southwest 2004–2014: Considerations for Local Therapies
Andrés Uribe, MD 1; Alexandra Cossio, RN MSc 2 and Maria Del Mar Castro, MD, MSc 1; 1Centro Internacional de Entrenamiento e Investigaciones Mèdicas (CIDEIM), Cali, Colombia, 2Universidad Icesi, Cali, Colombia
Session: 49. Global Health Potpourri
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Background. Systemic treatments for Cutaneous Leishmaniasis (CL) have many limitations. Local therapies are an alternative option for this disease. Available Pan-American Health Organization (PAHO) and World Health Organization (WHO) treatment guidelines were designed based on expert opinion considering clinical criteria for local treatment which influences feasibility of implementation of these treatment modalities. In this study, we evaluated the clinico-epidemiological profile and the eligibility for the use of local therapies with current guidelines of patients with CL at the Centro Internacional de Entrenamiento e Investigaciones Mèdicas (CIDEIM) from 2004 to 2014.
Methods. A descriptive study was conducted based on clinical records of adolescents (≥12 years) and adults (≥18 years) with confirmed parasitological diagnosis of tegumentary leishmaniasis. Incomplete or unconfirmed records were excluded. We applied JSF/ST criteria (≤3 lesions, diameter <5 cm, no disfiguring/incapacitating potential, no immunosuppression) and PAHO (single lesion, diameter ≤3 cm, any location except head and joints, absence of immunosuppression) to assess eligibility for local treatment.
Results. Among 3,691 records, a total of 1,834 met inclusion criteria. Fourteen percent of records were from adolescent patients and 86% were adults, all from southwestern Colombia. Regarding the clinical presentation of patients, most (57.3%) had a single
lesion and 86.2% had ≤ 3 lesions with a median = 2 cm (IQR 1–2). Lesions presented predominantly on upper limbs (40.9%), followed by lower limbs (23.2%). According to PAHO and WHO criteria, 18% (12.3% adult vs. 19.3%, P = 0.007) and 44.4% (adolescents 42% vs. adults 43%, P = 0.45), respectively, were eligible for local therapies.

Conclusion. Local therapies have feasible use in this population with mild and uncomplicated clinical presentation; however, its applicability is limited to current management criteria. Individualized risk—benefit assessment may increase eligibility.

Disclosures. All authors: No reported disclosures.

29.2. Systemic Cat Scratch Disease in Immunocompetent Adults: A Retrospective Case Series
Brazie Sheik, MD; Matti Drucker, MD; Neven Papic, MD, PhD; Isop Begovac, MD, PhD; and Adriana Vincen, MD, PhD
University of Hospital for Infectious Diseases Zagreb, Zagreb, Croatia, University of Zagreb, School of Medicine, Zagreb, Croatia

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Background. Cat-scratch disease (CSD) has worldwide distribution and is the most frequent presentation of Bartonella henselae infection. Systemic CSD has mainly been reported in immunocompromised children and immunosuppressed adults. The aim of this study was to assess the clinical and laboratory findings of systemic CSD in immunocompetent adults.

Methods. A retrospective, cohort study of all consecutive, immunocompetent adult patients diagnosed with systemic CSD in 10-year period (2007–2017), was conducted at the University Hospital for Infectious Diseases Zagreb. Diagnosis was established by serology (IgM > 1.20, IgG > 1.26 or the fourfold rise in IgG titer in the convalescent phase) or polymerase chain reaction (PCR).

Results. In total, 32 cases were identified, 23 males, mean age of 35 ± 16 years, and majority of the patients were recruited. Twenty-one patients (65.6%) were suspected of fever of unknown origin, nine (28.1%) with leptospirosis, one patient with oculoglandular with prolonged fever and one with parotitis. Thirty-nine (96.9%) patients were febrile for the 8.4 ± 5.6 days before hospitalization. Only 18.8% had concomitant lymphadenitis, 59.4% had headache, 28.1% abdominal pain and respiratory symptoms, 37.5% hepatomegaly and 31.3% splenomegaly on clinical examination. All except one patient had elevated CRP (70.8 ± 46.9), 12 patients (37.5%) had elevated WBC, 7 patients (21.8%) had elevated aminotransferases, and 4 patients (12.5%) had positive test for HIV. The diagnosis was established after 5.2 ± 5.3 days of hospitalization. Thirty (93.7%) received antibiotic treatment for the mean duration of 7.3 ± 5.8 days. All patients were cured without sequelae regardless of treatment.

Conclusion. Systemic CSD is not rare in healthy individuals. Since the diversity of the clinical manifestations in adults may be misleading, the infection should be suspected in patients with recent contact with a cat even despite the presence of lymphadenopathy.

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29.3. What Is Different When Dealing with Bacterial Brucellosis? Houda Ben Ayed, MD; Neven Papic, MD, PhD; Imed Maaloul, MD; Jennifer Manne-Goehler, MD, MPH

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Thursday, October 5, 2017: 12:30 PM

Background. Brucellosis is an acute febrile disease often associated with digestive complaints and biological inflammatory syndrome. In this perspective, our study aimed to determine predictive factors of bacteremia in patients with digestive complaints and biological inflammatory syndrome. In this perspective, our study aimed to determine predictive factors of bacteremia in patients with digestive complaints and biological inflammatory syndrome.

Methods. All authors:
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29.4. Follow-up Evaluation of Air Force Blood Donors Screening Positive for Chagas Disease
Joseph Marcus, MD; Thomas Cropper, DVM; Bryan Webber, MD, MPH; Matthew Wilson, DO and Heather Yun, MD, FIDSA
San Antonio Military Medical Center, Joint Base San Antonio-Fort Sam Houston, Texas, 2Preventive Medicine, U.S. Air Force, JBSA-Lackland, Texas, 3Trainee Health, US Air Force, JBSA-Lackland, Texas, 4Dept of Medicine, Infectious Disease Service, San Antonio Military Medical Center, Joint Base San Antonio-Fort Sam Houston, Texas

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Background. Chagas disease, caused by the protozoan parasite Trypanosoma cruzi, is endemic to Texas and has significant morbidity associated with its cardiac pathologies. The Joint Base San Antonio-Lackland (JBSA) represents a healthcare system with universal coverage to its beneficiaries and its blood bank screens all first-time blood donors for T. cruzi infection. Although there is a published, standardized approach for diagnosis and evaluation of Chagas disease in the United States, adherence to this approach has not been studied.

Methods. A retrospective chart review was performed on all persons who screened positive for T. cruzi on blood donation at JBSA from 2014 to 2016. Charts were reviewed to determine frequency and results of confirmatory testing, history and physical, EKG, and 30 second rhythm strip; outcomes of these evaluations were ascertained. Chagas disease was considered confirmed on the basis of positive EIA and TESA testing from the CDC and/or two different positive serologic tests.

Results. Of the 43,402 blood donors at JBSA, 23 screened positive for Chagas disease. Follow-up information was available on all 22 (95.7%). Seventeen (77%) were military trainees and 18 (82%) were male. Patients had a mean of 2.5 (range 1–5) additional serologic tests, with 13 different combinations of confirmatory tests ordered, including 17 (77%) who had the initial screening test repeated. Two patients (9%), both from Texas, met criteria for Chagas disease. One of these was diagnosed with cardiac pathology and underwent invasive investigatory separation from the Air Force. Eleven (50%) had Chagas disease excluded on the basis of two negative follow-up tests, and 9 (41%) had one negative follow-up test. All underwent history and physical, 15 (68%) had an EKG, and 5 (22%) had a 30 second rhythm strip. Fourteen (64%) were referred to infectious diseases.

Conclusion. Among a small cohort of active duty service members who screened positive for T. cruzi infection on blood donation, diagnostic workup, and evaluation varied considerably, despite universal access to no-cost medical care within a single system. Opportunities exist within the military health system to improve evaluation of persons who screen positive in the future.

Disclosures. H. Yun, American Board of Internal Medicine, Infectious Disease Board; Board Member, travel reimbursement, honorarium.