0.74 (95% confidence interval [CI]: 0.66 - 0.82). The cut-point was 2. A score ≥ 2 had a sensitivity of 87% (95%CI: 0.743 - 0.952), a specificity of 37% (95%CI: 0.308 - 0.445), a positive predictive value of 24%, and a negative predictive value of 93%, respectively.

Conclusion. We developed the score to help clinicians rule out IE in BHS bacteremia. Further research is warranted for validation.

Disclosures. All Authors: No reported disclosures

695. Antipseudomonal Versus Narrow-Spectrum Agents for the Treatment of Community-onset Intra-Abdominal Infections
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Session: P-33. Enteric Infection
Background. Antipseudomonal antibiotic regimens are often used to treat community-acquired intra-abdominal infections (CA-IAI) despite common causative pathogens being susceptible to more narrow-spectrum agents. The purpose of this study was to compare post-infection complications in adult patients treated for CA-IAI with antipseudomonal or narrow-spectrum regimens.

Methods. This retrospective cohort study included patients ≥ 18 years admitted for CA-IAI treated with antibiotics between January 1, 2013, and December 31, 2019. Patients who had bacteraemia or peritonitis were excluded. The primary objective of this study was to compare post-infection complications within 90 days between patients treated empirically with antipseudomonal versus narrow-spectrum regimens. Post-infection complications were defined as post-operative infection, recurrence of diverticulitis, or mortality. Secondary objectives were to compare infection and treatment characteristics along with post-operative outcomes. Sub-group analyses were planned to compare outcomes in patients with low- and high-risk of recurrent CA-IAI and patients who required surgical intervention versus those who were medically managed.

Results. A total of 350 patients were included: Antipseudomonal, n=204; Narrow-spectrum, n=146. There were no differences in 90-day post-infection complications between groups (Antipseudomonal 15.1% vs Narrow-Spectrum 11.3%, p=0.326). Additionally, no differences were observed in hospital LOS, 90-day readmission, C. difficile, or mortality. Patients treated with Antipseudomonal regimens received longer durations of therapy (median 11 days [IQR 8-14] vs 9 days [IQR 5-12], p<0.001). No differences were observed in 90-day post-infection complications for patient with low-risk (Antipseudomonal 15% vs Narrow-spectrum 9.6%, p=0.154) or high-risk CA-IAI (Antipseudomonal 15.8% vs Narrow-spectrum 22.2%, p=0.588), or those who were surgically treated (Antipseudomonal 8.5% vs Narrow-spectrum 9.2%, p=0.877) or medically managed (Antipseudomonal 17.5% vs Narrow-spectrum 13.1%, p=0.463).

Conclusion. Post-infection complication rates were similar among patients treated with antipseudomonal and narrow-spectrum antibiotics. Antipseudomonal therapy is likely unnecessary for most patients with CA-IAI.

Disclosures. Lisa E. Dumkow, PharmD, BCIDP, Nothing to disclose

696. Optimal Duration of Prophylactic Antibiotics in Patients with Cirrhosis and Upper Gastrointestinal Bleeding
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Session: P-33. Enteric Infection
Background. Spontaneous bacterial peritonitis (SBP) is a serious complication of variceal hemorrhage. Guidelines recommend a maximum of seven days of antibiotics after variceal hemorrhage to prevent SBP and reduce mortality. However, studies supporting these guidelines used varied durations of therapy including those with less than seven days. The objective of this study was to determine if less than seven days of antibiotic prophylaxis was noninferior to seven or more days in patients with cirrhosis and variceal hemorrhage.

Methods. This was a single-center, retrospective cohort conducted from August 2019 to August 2020 including adult patients who received treatment for variceal hemorrhage and antibiotics for prevention of SBP during hospitalization. Patients were excluded if they were diagnosed with non-variceal hemorrhage, received treatment with antibiotics within 72 hours prior to the variceal hemorrhage, or expired or transitioned to end of life care within 48 hours of hospital admission. The primary outcome was in-hospital mortality. Secondary outcomes included SBP within the first 30 days after variceal hemorrhage, 30-day mortality, 30-day readmission rate, incidence of rebleeding at seven and 30 days, incidence of Clostridioides difficile infection, and intensive care unit and hospital length of stay.

Results. 64 patients were included with 45 patients in the less than seven days group and 19 patients in the seven or more days of antibiotic prophylaxis group. In each group, patients were primarily male with a median age of approximately 60 years. There was no difference in the primary outcome of in-hospital mortality between the less than seven days group as compared to the seven or more days group (22.2% vs 0%, p=0.1). No differences were observed between the less than seven days group as compared to the seven or more days group for any of the secondary outcomes.

Conclusion. This study identified no difference in patient-centered outcomes when comparing less than seven days of prophylactic antibiotics to seven or more days in patients with variceal hemorrhage. Less than seven days of prophylactic antibiotics may be a reasonable duration for prevention of SBP.

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697. Outcomes of Tigecycline Use for Clostridioides difficile Infection: A Case Series of 28 Patients
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Session: P-33. Enteric Infection
Background. Clostridioides difficile infection remains a highly morbid or lethal condition in an unacceptably large proportion of patients. To date, there are limited and conflicting data to support the use of tigecycline for C. difficile infection and the optimal stratification approach, timing (i.e., initial vs salvage therapy), and duration are unclear.

Methods. In this describe a retrospective cohort of 28 C. difficile patients treated with tigecycline at UVA Medical Center. We stratify each patient by the Infectious Diseases Society of America (IDSA) guidelines for treatment of infection and detail the timing and duration of tigecycline therapy in each case. We further characterize the effect of tigecycline on 90-day mortality and recurrence.

Results. 9/28 (32.1%) patients were treated with tigecycline for fulminant (presence of hypotension, shock, ileus, or megacolonic), and 12/28 (43.1%) for a white blood cell count over 15x10⁹/L or creatinine over 1.5mg/dL. C. difficile infection. Tigecycline was used in all cases in combination with oral vancomycin +/- metronidazole. The average duration of therapy was 7.6 days, with tigecycline as initial therapy (use within the first 72 hours of the start of directed antimicrobial therapy) in 7.5% of cases. 90-days post-infection complications (one of which was in-hospital mortality and five (50%) patients that reached 90-day follow-up) occurred in patients with fulminant infection. 7 of the 16 (43.8%) surviving patients that reached 90-day follow-up had recurrent C. difficile infection.

Conclusion. Patients selected for treatment with tigecycline for C. difficile infection suffered a high rate of in-hospital mortality, especially among the significant proportion with fulminant disease. The rate of recurrent infection was substantial, contrary to some reports of reduced recurrence with tigecycline from the literature. The outcomes of tigecycline (as adjunct or monotherapy) for treatment of severe/fulminant and refractory infection versus standard treatments warrant further retrospective analysis and the benefit of tigecycline in these settings remains to be proven in well-controlled clinical trials.

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698. Contemporary Clinical Epidemiology of Pediatric Shigellosis and Campylobacter Infections in Houston, TX, 2019 and 2020.
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Session: P-33. Enteric Infection
Background. Infections due to Gram-negative, diarrheal pathogens are a significant cause of morbidity in children. Clinical features of pediatric Shigella and Campylobacter infections in urban cities in the United States are not well described.

Methods. We used a retrospective chart review of records 0-18 years of age from a network of hospitals in Houston, TX. Only patients with Shigella spp. or Campylobacter spp. isolated from clinical samples in 2019 and 2020 were included. Demographic, clinical, and microbiological data were extracted from the medical record.

Results. We identified a total of 59 and 16 pediatric patients with Shigella spp. and Campylobacter spp. infections, respectively. Hospital admission occurred in 27.1% (16/59) of Shigella and 25% (4/16) of Campylobacter. Length of stay ranged between 1 and 2 days for both pathogens (Table 1). Of cases with available clinical data, Shigella infections were more likely to report fever during their illness compared to Campylobacter (80% versus 45.4%) (Table 2). Seizures were observed in 4 Shigella infected patients. No episodes of Shigellosis or Campylobacter bacteremia were identified. Among patients with an identified exposure, daycare attendance and contact with individuals experiencing similar symptoms were most common (Table 2). The vast majority of Shigella species were S. sonnei (96.6%) and all Campylobacter were C. jejuni (Table 3). Resistance to trimethoprim-sulfamethoxazole (TMP-SMX) was common (40/55, 72.7%) among Shigella isolates tested. No resistance to fluoroquinolones or third generation cephalosporins in any of the Shigella spp. isolates was observed. Shigella spp. and Campylobacter spp. isolates were not identified between the less than seven days group as compared to the seven or more days group for any of the secondary outcomes.

Conclusion. The most frequent antibiotic used was azithromycin (in 73.3% and 75% of patients with Shigella and Campylobacter, respectively). Major complications included urinary tract infection (n=1), rectal prolapse (n=1) and splenomegaly (n=1).