encephalitis. High dose sulfamethoxazole/trimethoprim was given due to suspicion of autoimmune encephalitis. MRI brain showed cerebral atrophy. There was slight abnormality on FLAIR/T2 signal within the medial aspect of the temporal lobes, right more than left.

Results. Occupational history revealed that he was a logger by profession, which steered our focus on tick borne diseases. Extensive serologic evaluation was requested and RMSF IgG titres came back positive at 1:512. Doxycycline was added, while ampicillin and ceftriaxone were discontinued. With doxycycline, patient made remarkable recovery and was discharged home well. However, he returned within 48 hours with recurring encephalopathy. His clinical presentation remained convincing for RMSF encephalitis, with the natural course of the illness spanning over weeks, with waxing and waning symptoms. Patient was managed with IV doxycycline for 72 hours following which he returned to his baseline mental status.

Figure 3. CSF studies

| INVESTIGATIONS | RESULTS |
|----------------|---------|
| ARBOVIRUS PANEL | Non Reactive |
| • Apparented Alline | <1:1 (1:1) |
| • Califonia Encephalitis Virus IgG & IgM | <1:1 (1:1) |
| • St Louis Encephalitis Virus IgG & IgM | <1:1 (1:1) |
| • Western Equine Encephalitis Virus IgG & IgM | <1:1 (1:1) |
| ERICHLA ANTIBODY | IgM antibody |
| | <1:1 (1:50) |
| ENTEROVIRUS RNA | Not detected |
| HEPATITIS A IgM | Not reactive |
| HEPATITIS B ANTIGEN | Non reactive |
| HEPATITIS B ANTIBODY | Non reactive |
| HEPATITIS C ANTIBODY | Non reactive |
| HSV 1 & 2 PCR | Not detected |
| RICKETTSIA ANTIBODY | Detected |
| • RMSF IgG | Not detected |
| • RMSF IgM | Not detected |
| • R Typhi IgG | Not detected |
| RICKETTSIA IgG | 1:512 (1:54) |
| SARS CoV (RT-PCR) | Negative |
| VARV DNA (PCR) | Not detected |

Conclusion. Patient’s occupation played a pivotal role in establishing diagnosis. In RMSF, IgM and IgG antibodies appear 7 to 10 days after the onset of the illness, and a fourfold rise in IgG is diagnostic of seroconversion and recent illness. Patient’s waxing and waning symptoms, persisting for weeks and remarkable response to doxycycline, are typical features of RMSF encephalitis.

Disclosures. All Authors: No reported disclosures

266. A Rare Case of Human Herpesvirus-6 (HHV-6) Encephalitis in an Immunocompetent Host
Ali M. Ayyash, MD MPH MS; Muhammad Kurtom, DO; Charlie Ervin, MD; Mark Irwin, DO; Rahul Sampath, MD; Carolinas Medical Center, Morganton, North Carolina; Carolinas Medical Center Blue Ridge, Morganton, North Carolina; Carolinas Healthcare System, Morganton, North Carolina; Carolinas HealthCare System Blue Ridge, Morganton, North Carolina; Carolinas HealthCare Systems Blue Ridge, Morganton, NC

Session: P-13 CNS Infection

Background. Human Herpesvirus-6 (HHV-6) seroprevalence rates in the United States range from 72-95%, but clinical illness in the adult population is extremely rare, which often presents as meningoencephalitis in immunocompromised hosts. The literature on HHV-6 encephalitis in immunocompetent adults is limited to a select number of case reports, ultimately providing scant treatment guidance for clinicians.

Methods. This is a unique case describing the clinical course of confirmed HHV-6 encephalitis in an immunocompetent host.

Results. The patient is a 77-year-old immunocompetent female presenting with two days of global aphasia and increased muscle tone. She presented hypertensive with a leukocytosis. Work-up for acute stroke was unremarkable, but lumbar puncture revealed an elevated white blood cell (WBC) count of 39 leukocytes/mm³ with a lymphocytic predominance. BioFire FilmArray Meningitis/Encephalitis panel (FAME) demonstrated positivity for HHV-6 with a viral load of 8,500 copies/mL in the cerebrospinal fluid (CSF) and 4.1 million copies/mL in serum. The patient experienced temporary improvement in her aphasia after being initiated on intravenous (IV) ganciclovir for 12 days. Shortly after the initiation of therapy, her aphasia worsened with repeat CSF studies demonstrating an increased viral load to 35,700 copies/mL. She was subsequently transitioned to IV foscarnet for HHV-68 coverage and discharged after completing 11 days of therapy with marked improvement in her symptoms. Two weeks later, the patient was readmitted for recurrence of aphasia. MRI brain at that time was unremarkable with repeat lumbar puncture demonstrating a WBC count of 8 with 113 copies/mL of HHV-6. Serum levels were also elevated to 4.7 million c/mL. The patient was restarted on foscarnet but continued to deteriorate clinically. She ultimately experienced multiple seizure-like episodes resulting in a noncommunicative, somnolent state. She was transitioned to hospice care and passed away 2 days after discharge.

Conclusion. Despite the use of recommended medical therapies, the mortality and clinical progression of HHV-6 in immunocompetent adults is still unpredictable. Further studies are needed in this population to provide guidance for clinicians.

Disclosures. All Authors: No reported disclosures

267. Therapeutic Management of Bacterial Brain Abscess: An Overview of Diagnosis and Outcomes
Cristina G. Corsini, MD; John Raymond U. Go, MD; John C. O’Horo, Sr., MD, MPH, DO; M. Rizwan Sohail, MD; M. Rizwan Sohail, MD, DO; Mayo Clinic Rochester, Rochester, MN; Mayo Clinic Rochester, Rochester, MN; Baylor College of Medicine, Sugarland, TX

Session: P-13 CNS Infection

Background. We describe and compare the clinical, diagnostic evaluation and outcomes of patients who underwent therapeutic management for pyogenic brain abscesses.

Methods. We retrospectively reviewed adults who presented with pyogenic brain abscess from January 1, 2009 through June 30, 2020.

Results. 231 patients were identified during the study period. Sixty-one (26.4%) patients received antibiotic therapy alone, and 170 (73.6%) had a combination of antibiotic therapy and surgical intervention. The median age for the medical and combined therapy group was 59 years and 58 years, respectively. Patients who received medical treatment had a higher prevalence of infective endocarditis than those who received...
combined therapy (6.6% vs. 0.6%; P=0.005). The medical therapy group was more likely to have brain MRI and cranial CT than the patients with combined therapy (75.4% vs. 63.5%; P=0.041). Midline shift (11.5% vs. 31.2%; P=0.002), a single (21% vs. 83%; P=0.001) and greater size (1.4 cm vs. 2.5 cm; P=0.007) brain abscess was significant when comparing medical vs. surgically managed abscess. Stereotactic surgical technique was the preferred diagnostic approach for the medical group (65.6% vs. 46.5%; P=0.010), and excision/craniotomy for the combined group (31.1% vs. 53.5%; P=0.002). Streptococcus viridans group was the predominant organism (32.8% and 25.9%; P=0.30). Compared to those who received combined therapy, patients with medical therapy alone were most likely to receive cephalosporin (72.1% vs. 41.2%; P=0.0001), vancomycin (23% vs. 12.4%; P=0.047) and metronidazole (27.9% vs. 14.7%; P=0.022). In both groups, median duration of antimicrobial therapy was 42 days (P=0.12). Patients with medical therapy alone had a higher mortality rate (18% vs. 7.1%; p=0.014) but less neurologic sequelae (21.3% vs. 30.6%; P=0.16) compared with combined therapy.

Medical Management. Organism isolated in the medical management group

Combined Management. Organism isolated in the combined management group

Demographic and Clinical Characteristics of Patients with Brain Abscess who Underwent Therapeutic Management

Outcomes of Patients with Bacterial Brain Abscess:

|                          | Medical management, n=61 | Combined medical/surgical management, n=179 | P-value |
|--------------------------|--------------------------|---------------------------------------------|---------|
| **Cured without permanent neurologic deficits, n (%)** | 28 (45.9)                | 76 (44.7)                                   | 0.67    |
| **Size*, cm, median (IQR)** | 1.6 (1-2.8)             | 1.6 (1-2.9)                                 | 0.88    |
| **Single*, n (%)**       | 22 (35)                  | 59 (33)                                     | 0.84    |
| **Cured with permanent neurologic deficits, n (%)** | 13 (21.3)                | 52 (30.0)                                   | 0.16    |
| **Hemiparesis**          | 2                        | 7                                           | 0.77    |
| **Hemiplegia**           | 2                        | 13                                          | 0.23    |
| **Mortality**            | 1                        | 2                                           | 0.74    |
| **Midline shift**        | 11 (18%)                 | 43                                           | 0.25    |
| **Re-operation**         | 2                        | 6                                           | 0.92    |

**Abbreviations:** IQR, interquartile range; n, number.

*Hydrocephalus, persistent headache, dysphagia.

*Abscesses.

Radiologic and Surgical Diagnosis of Patient with Brain Abscess who Underwent Therapeutic Management

| Factor          | Medical management (n=61) | Combined medical/surgical management (n=179) | P-value |
|-----------------|---------------------------|---------------------------------------------|---------|
| **Imaging technique, n (%)** |                           |                                             |         |
| Cranial CT      | 51 (85.2)                 | 138 (78.3)                                  | 0.24    |
| Brain MRI       | 46 (76.8)                 | 148 (84.1)                                  | 0.32    |
| **Failure**     |                           |                                             |         |
| Death           | 11 (18%)                  | 12 (7.1%)                                   | 0.014   |
| **Re-operation**| 2                         | 6                                           | 0.92    |

**Abbreviations:** IQR, interquartile range; MRI, magnetic resonance imaging; n, number.

*Abscitec. 

*S. otaqua, T-test.

**Disclosures.** John C. O’Horro, Sr., MD, MPH, Bates College and Elsevier Inc (Consultant) M. Rizwan Sohail, MD, Medtronic Inc., Philips, and Azylo Biologics, Inc (Consultant) M. Rizwan Sohail, MD, Azylo Biologics (Individual(s) Involved: Self); Consultant; Philips (Individual(s) Involved: Self). Consultant

268. Methicillin Sensitive Versus Methicillin Resistant *Staphylococcus aureus* Nosocomial Meningitis

Deniz Akyol, Doctor1; Selin Bardak özcem, n/a; Sinan Mermer, n/a1; Şöhret Aydemir, n/a2; Tansu Yamanbazan, Professor Doctor1; Bilgin Arla, MD2; Erkin Özgüray, n/a3; Taşkın Yurtseven, n/a2; Sercan Ulusoy, Professor Doctor2; Oğuz Reşat Sipahi, Professor Doctor3; Doctor, İzmir, Izmir, Turkey; Ege University Faculty of Medicine, İzmir, Izmir, Turkey; Professor Doctor, İzmir, Izmir, Turkey

**Session:** P-13. CNS Infection

**Background.** Herein, we aimed to analyze the outcomes of the methicillin sensitive (MS) versus methicillin resistant (MR) culture-proven *Staphylococcus spp.* nosocomial meningitis (N-NM) in our setting.

**Methods.** We extracted data and outcomes for all adult patients (age ≥18years) consulted by the Infectious Diseases Consultants and diagnosed NM (developed at a compatible time according to CDC nosocomial meningitis definitions) between January 2006 and 2021 and fulfilled the following study inclusion criteria: (a) Age ≥18-year-old; (b) CSF culture is positive for *Staphylococcus* spp. (c) Presence of at least two of three clinical/laboratory criteria as meningitis findings: (i) Body temperature >38°C.