of VOR/POS TDM among Southeast Asians that are predominantly intermediate/poor VOR metabolizers.

Methods. All adults with VOR/POS TDM performed at our institution from 2015 to 2018 were included. We determined proportion of patients and doses required to achieve TDM targets ([2–5.5 mg/L (VOR) or 2.0 and 1.8 mg/L (POS prophylaxis and treatment respectively)], and correlate levels with treatment efficacy and safety.

Results. VOR/POS TDM was performed mostly among patients with hematological malignancy or solid-organ transplant (43/174, 83.9%). Less than half (32/70, 45.7%) of patients on VOR achieved target—18 (25.7%) were < 2 mg/L while 20 (28.5%) had trough levels < 0.7 mg/L. Doses required to achieve TDM target ranged from 1.9–11.4 mg/kg/day. Drug interactions, critically ill state and change in drug formulation were major causes of intra-patient variability. One-fifth (n = 14) experienced transaminosis; corresponding VOR trough levels were 0.5–> 7.5 mg/L. Neurotoxicity was seen in 4 patients (3.4%); all had VOR trough 2.6 mg/L and saw symptom resolution upon dose reduction. There appears to be no association between the achievement of TDM targets and response rates. Majority (81/104, 77.9%) of patients on POS achieved TDM targets. Patients prescribed POS tablet were significantly more likely to attain targets compared with suspension 600 mg/day [19/26 (73.0%) vs. 27/62 (43.5%), P < 0.05] and 800 mg/day [17/26 (65.3%) vs. 4/16 (25.0%), P < 0.05]. Of 23 with sub-therapeutic levels, 19 (82.6%) responded to dose increase and/or change in acid-reducing agents. Breakthrough infection occurred despite troughs ≥ 0.7 mg/L [5/42 (11.9%) vs. 2/40 (5.0%) when < 0.7 mg/L (P = 0.3)]. Treatment failure was observed in 2 patients (troughs > 10 mg/L).

Conclusion. VOR/POS TDM should be implemented in Southeast Asians due to significant unpredictability in dose exposure and potential to avoid need for switch to alternative anti-fungal due to intolerability. Higher POS trough cutoff may be required for effective anti-fungal prophylaxis.

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2108. Comparison of Voriconazole vs. Itraconazole in the Treatment of Histoplasmosis – A Retrospective Analysis
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Background. The guideline-preferred azole for histoplasmosis (HP) is itraconazole (IC). While voriconazole (VC) has shown success in in-vitro and in retrospective analyses, there has not been enough data to include newer generation azoles as first-line treatment for infections with Histoplasma capsulatum.

Methods. We conducted a single-center retrospective cohort study of adult patients diagnosed with HP from 2002 through 2017. Data included demographics, clinical features and sites of infection, immune status, treatments, and mortality. Patients were categorized into two groups based on initial choice of azole (IC or VC) and mortality was compared between these two groups. The treatment groups were defined based on the first azole received, either IC or VC, as initial or as a step-down therapy from amphotericin. Patients initiated on other azoles were excluded.

Results. We identified 263 cases of HP from 2002 to 2017. After excluding patients who were switched or who were initiated on other azoles, 194 patients remained. 175 (90%) patients were started on IC and 19 (10%) were started on VC, either as stepdown or initial choice of antifungal. There were no significant demographic differences between patients receiving IC compared with VC as their initial treatment azole. Patients with hematologic malignancy were more likely to be prescribed VC more frequently but this was not statistically significant (OR 3.1 [0.77–12.4]). Death occurred in 40 (23%) patients from the IC and 5 (26%) patients from the VC group. The hazard ratio for mortality with the use of VC was 1.21 (CI 0.4–3.6, P = 0.73).

Conclusion. IC is the mainstay in the treatment for HP. It appears that VC has comparable outcomes to IC and can be considered an alternative treatment option for HP, at least for patients with contraindications to IC treatment.