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. baumannii*, *C. diphtheriae*, and *C. kerver* were isolated in BC. Performance characteristics of T2 and BC in the two groups are shown (Table 2). Of the 12+TIR-BC– cases (n = 112), 9% had retinoids 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 (3.01%)        | 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      | 93.3%        | 46.1%             |         |
| Specificity      | 81.9%        | 92.4%             |         |
| PPV              | 20.8%        | 28.9%             |         |
| NPV              | 98.8%        | 96.2%             |         |

**Disclosures.** G. Alangaden, T2 Biosystems: Speaker's Bureau, Educational grant and Speaker honorarium.

### 1137. Implementation of Universal Screening for Strongyloidiasis Among Solid-Organ and Hematopoietic Stem Cell Transplant 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.** Strongyloidiasis can lead to hyperinfection and dissemination after transplantation with significant morbidity and mortality. Treatment for Strongyloidiasis 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 serum Strongyloides IgG by ELISA during pre-transplant evaluation for SOT or HSCT from August 1, 2017 to April 25, 2018. We reviewed adverse events 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. 204 (24.7%) of the 812 patients were screened for Strongyloides. Of those, 985 were unique patients (62 patients had multiple serological tests). Three patients had invasive for strongyloides and Strongyloides IgG testing. Patients were excluded if they had other immunocompromising conditions or exposures including but not limited to steroids, TNF-α inhibitor, or biologic agent use. The primary outcome was the overall prevalence rate of Strongyloides at OMC.

**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.

### 1138. Retrospective Cohort Analysis of Amphotericin B Nephrotoxicity in Kidney Transplant Recipients

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**Session:** 134. Fungi and Parasites in Immunocompromised Patients

**Friday, October 5, 2018: 12:30 PM**

**Background.** Amphotericin B is a critical antifungal therapy in renal transplant recipients and is associated with dose-related nephrotoxicity. Previous studies have assessed the impact of nephrotoxicity on patient survival and graft function in renal transplant patients. To our knowledge, no study has assessed the impact of Amphotericin B nephrotoxicity on graft function in a cohort of renal transplant recipients.

**Methods.** This was a retrospective cohort analysis of renal transplant recipients at a single tertiary care center from January 2015 to February 2016. Amphotericin B was prescribed for 3,726 patient-years of follow-up in 338 patients. The primary outcome was the development of acute kidney injury (AKI) defined as an increase in serum creatinine ≥0.5 mg/dL from baseline, or a ≥ 50% increase from baseline to >2.5 mg/dL within 48 hours, or the need for renal replacement therapy. The secondary outcome was progression to chronic kidney disease (CKD) stage 3 or greater defined as a serum creatinine ≥1.5 mg/dL. The primary endpoint was the development of AKI within the first 30 days of starting Amphotericin B therapy. The secondary endpoint was progression to CKD stage 3 or greater within 30 days of starting Amphotericin B therapy. The primary endpoint was the development of AKI within the first 30 days of starting Amphotericin B therapy. The secondary endpoint was progression to CKD stage 3 or greater within 30 days of starting Amphotericin B therapy. The primary endpoint was the development of AKI within the first 30 days of starting Amphotericin B therapy. The secondary endpoint was progression to CKD stage 3 or greater within 30 days of starting Amphotericin B therapy.