bacteremia, 30-day all-cause mortality and adverse events (AEs) necessitating a change in therapy.

**Results.** Among patients with MSSA bacteremia, 162 received at least one dose of daptomycin. Of those, 29 received at least 14 days of daptomycin and/or received daptomycin as definitive therapy and thus were included in the analysis. There was no difference in the primary endpoint of clinical failure between daptomycin vs. nafcillin/cefazolin ($P=0.71$). In addition, no difference was observed in 30-day infection-related mortality ($P=0.51$), duration of MSSA bacteremia ($P=0.9$), or 30-day all-cause mortality ($P=0.64$). A higher number of AEs necessitating change in therapy were seen in the daptomycin group ($P=0.0002$), reflecting initial $β$-lactam intolerance.

**Conclusion.** No difference in clinical failure was identified in patients treated with daptomycin vs. nafcillin/cefazolin suggesting that daptomycin may serve as a non-inferior alternative for treatment of MSSA bacteremia. A higher number of AEs occurred in the daptomycin group indicating $β$-lactam intolerance as a primary indication for daptomycin therapy. Given the small sample size, subsequent studies are needed to further evaluate the use of daptomycin in the treatment of MSSA bacteremia.

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178. Evaluation of Oral Antibiotic Stepdown Therapy for the Management of Gram-Negative Rod Bacteremia in a Tertiary Care Medical Center

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**Session:** 37. Bacteremia, CLABSI, and Endovascular Infections

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**Background.** Treatment strategies surrounding bacteremia are constantly changing as new data emerges. Transition from intravenous (IV) to oral (PO) antibiotics in patients with Gram-negative rod bloodstream infections (GNR BSIs) remains controversial. The objective of this study was to characterize clinical outcomes in patients who received early (≤72 hours) vs. late (>72 hours) stepdown therapy (ES vs. LS, respectively) for GNR BSIs.

**Methods.** A single-center, retrospective cohort study was conducted including adults with GNR BSIs admitted to a 713-bed tertiary care medical center between January 1, 2016 and December 31, 2017 who were transitioned from IV to PO antibiotics. Patients with severe renal impairment, inadequate source control, prolonged antibiotic course, HIV/AIDS, and pregnancy were excluded. The primary endpoint was clinical failure and secondary endpoints were 30- and 90-day all-cause mortality, duration of bacteremia, and adverse events.

**Results.** 164 patients (ES = 61; LS = 103) were included. Population median age was 63 years, 56% were male, and 19% were immunocompromised. Genitourinary source was most common (48.7%); while the most common organism isolated was *Escherichia coli* (52.4%). Most infections were community-acquired (70.1%) and the most common step-down therapy choice was ciprofloxacin in 75% of patients. There were no major differences in baseline demographic and clinical characteristics between groups except for the greater presence of central venous catheters (14.6% vs. 35.9%; $P = 0.006$) in the LS group. Overall clinical failure was 9.8% vs. 13.6% between the ES and LS groups, respectively. The LS group had a higher rate of clinical failure defined by escalation from PO to IV antibiotics (1.6% vs. 10.7%; $P = 0.03$). Patients who failed therapy tended to be immunocompromised and/or have an intra-abdominal source of infection. Secondary endpoints did not differ between groups.

**Conclusion.** Higher clinical failure rates in the LS group indicate that these patients may have underlying clinical characteristics not amenable to stepdown therapy. Choice of step-down therapy was not driven by the source of infection or patient safety. Further analysis and studies are needed to determine optimal time and population for stepdown.

**Disclosures.** All authors: No reported disclosures.