254. National Trends in the Japanese Distribution of Major Candida Species Causing Candidemia During 2003–2017: A Report by the Epidemiological Investigation Committee for Human Mycoses in Japan
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Background. Candida species are a common cause of nosocomial bloodstream infections, and candidemia is associated with high mortality rates among adults and neonates. There is limited epidemiological data regarding candidemia in Japan. Therefore, the Epidemiological Investigation Committee for Human Mycoses in Japan performed a retrospective epidemiological survey of candidemia and causative Candida species.

Methods. Blood culture results from 2003 to 2017 were retrospectively evaluated. The data included the center-specific numbers of annual blood cultures, bacterial isolates that included fungi, numbers of fungi, and Candida species. Data were collected from 10 Japanese university hospitals located on all over Japan.

Results. A total of 433,961 blood cultures were included. The prevalence of fungi in all cultures and in positive cultures were 0.53 ± 0.07 and 3.78 ± 0.47%, respectively. Among the results that were positive for Candida species (N = 2,270), C. albicans was the most common species (39.2%) and was followed by C. parapsilosis (22.8%), C. glabrata (15.6%), C. tropicalis (9.7%), C. krusei (2.2%), and others. And the temporal changes in the five major Candida species’ distributions were analyzed. The frequency of C. albicans was 48% in 2003 and 2004, approximately 40% during 2005–2011, approximately 30% in 2012 and 2014, and 40% in 2015–2017. The next most common species were C. parapsilosis and C. glabrata. The frequency of C. parapsilosis and C. glabrata was approximately 16% in 2003, approximately 28% during 2005–2009 and 21.7% during 2010–2017. There was a significant difference in the C. parapsilosis rates for the first and second halves of the study period (24.8% vs. 21.7%, P = 0.03). The frequency of C. glabrata was <10% during 2004–2006, 9.5% and 17% after 2010. C. glabrata was significantly more common in the second half of the study period, compared with the first half (12.0% vs. 17.3%, P = 0.004). The frequency of C. tropicalis remains stable, and C. krusei was significantly less common in the second half of the study period.”

Conclusion. The frequency of C. albicans has varied in each year in Japan, while that of C. glabrata has increased. Additional surveys are needed to continuously monitor the trends in the distribution of candidemia in Japan.

Disclosures. All authors: No reported disclosures.

255. Breakthrough Mucormycosis (BT-MCR) on Antifungals Having Mucorales Activity Portrays Worse Prognosis Compared with BT-MCR on Mold-Active Antifungals with no Mucorales Activity
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Background. BT-MCR is known to develop in the setting of agents having Mucorales activity but no Mucorales activity. However, BT-MCR can occur even with the use of antifungals having with Mucorales activity in patients with hematologic malignancies and or stem cell transplant (HMT).

Methods. We reviewed the records of HM patients treated for MCR (1994 to 2019) at MD Anderson Cancer Center. We identified patients with BT-MCR on antifungals having Mucorales activity: posaconazole (POSA), itraconazole (ITZ), and amphotericin B (AMB) and patients with BT-MCR on agents having Mucorales activity: voriconazole (VRC), itraconazole (ITZ), echinocandins (group B). BT-MCR was defined as MCR diagnosis (dx) after 2-7 days (d) of antifungal use. The primary outcome was 42d mortality after the BT-MCR dx. Chi-square or Fisher’s exact test was used for categorical variables and Wilcoxon rank-sum test used for continuous variables. Cox regression model was used to evaluate the independent variables on outcome. Cox regression model was used to evaluate the independent variables on outcome.

Results. We identified 11 patients in group A (3 POSA, 5 ISA, 3 AMB) and 81 patients in group B (61 VRC, 13 echinocandins, 7 ITZ). Both groups were not different in terms of age, sex, underlying HM (AML/MDS in 100% vs. 88% in groups A and B, respectively), status of HM (active disease in 82% vs. 67%), prior stem cell transplant (45% vs. 54%) or GVHD (80% vs. 84%), neutropenia at dx (55% vs. 42%), prior receipt of ≥600 mg of prednisone (45% vs. 41%) or ICU at MCR dx (36% vs. 26%). Similarly, Mucorales species (Rhizopus spp. in 55% vs. 49%) and type of infection (surgical or hematologic) in 73% vs. 68% were not different between the groups. However, both d42 (82% vs. 46%, P = 0.025) and d84 (100% vs. 60%, P = 0.007) mortality was worse in group A. Similarly, median time to death was faster in patients in group A (26d, range 7-90d), vs. group B (42d, range 4-314d, P = 0.031). Kaplan-Meier analysis showed a similar difference (Figure 1). In multivariate analysis, neutropenia (P = 0.038) and ICU at dx (P = 0.002) were independent factors on day 42d mortality in all 92 patients with prior Mucorales–active antifungals showing a trend associated with poor outcome (P = 0.17).

Conclusion. BT-MCR on agents having Mucorales activity is a marker of poor prognosis in HM patients. Early use of investigational immunotherapy and salvage antifungal chemotherapy studies is needed in that subgroup of patients.

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256. Optimizing the Clinical Utilization of T2 Rapid Candida Panel at a Large Community Hospital
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Background. Candidemia is the fourth leading hospital-acquired bloodstream infection with an estimated mortality rate of 35%. Fungal blood cultures result in at least five days and fail to identify 40% of Candida infections. The T2 Candida Panel is a diagnostic test which utilizes whole blood to provide rapid detection of five Candida varieties. It has a 91% sensitivity and 99% specificity rate and enables physicians to initiate or de-escalate therapy rapidly, possibly decreasing mortality. However, practical utilization clinically has not been studied. Our aim is to evaluate the appropriate utilization of the T2 Candida Panel in a large community hospital.

Methods. A retrospective chart review of hospitalized with a T2 Candida Panel result from December 2015 to June 2018 was performed. The panel was restricted and could only be ordered by two specialties, Infectious Disease and Oncology. Baseline demographics and patient characteristics were collected. Endpoints assessed included patient outcomes, antifungal medication use, T2 Candida panel results, corresponding blood culture results, time to appropriate therapy and duration of therapy.

Results. A total of 628 T2 Candida panels resulted during the study period with 56.6% involving the intensive care setting. The average age was 59.5 years with 52.5% of the population being male. Of the total, 8.1% (n = 60) were positive. Only three patients had a positive fungal blood culture result with a negative T2 panel collected at the same time (sensitivity 94.3%, 95% CI 80.8–99.3; specificity 94.2%, 95% CI 91.4–96.3). 264 (42%) were ordered with concomitant antifungal therapy and 48.1% underwent de-escalation of therapy. The variation in utilization of the T2 Candida Panel indicates that further intervention regarding appropriate use of the panel is required.

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