using the Fisher exact or Chi-square and t-test for categorical and continuous data, respectively.

**Results.** Of the 12,893 evaluated RDT results in the pre-intervention group and 2,238 post intervention, 41 and 12 patients met inclusion criteria, respectively. Baseline characteristics were similar in both groups. Time to de-escalation to a target agent was decreased by 24 hours after stewardship intervention (50 v 74.6 hours) (P = 0.14). There were no statistically significant differences in DOTs for target agents (5.19 v 5.25 DOT; P = 0.48), carbapenems (1.29 v 1.08 DOT; P = 0.41), or NCAP β-lactams (1.73 v 2.33; P = 0.25). Treatment failure (2 in each group; P = 0.17) and LOS (10.9 v 11.9 days; P = 0.4) were similar between groups. Protocol compliance and intervention acceptance rate was approximately 60%.

**Conclusion.** Appreciation of NPVs and utilization of stewardship intervention allowed for early de-escalation of empiric therapy in patients with resistance marker-negative E. coli and K. pneumoniae bacteremia.

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

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**Average DOT – Carbapenem**

| Days | Pre-intervention | Post-intervention |
|------|------------------|-------------------|
| 1.29 |                  |                   |
| 1.08 |                  |                   |

**Student’s t-test; P = 0.04**

**Average DOT – Target Agent**

| Days | Pre-intervention | Post-intervention |
|------|------------------|-------------------|
| 5.19 |                  |                   |
| 5.25 |                  |                   |

**Student’s t-test; P = 0.48**

**Average DOT – NCAP Beta-Lactams**

| Days | Pre-intervention | Post-intervention |
|------|------------------|-------------------|
| 1.73 |                  |                   |
| 2.33 |                  |                   |

**Student’s t-test; P = 0.25**

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**193. Comparison of Survival for MSSA and MRSA Endocarditis**

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

**Thursday, October 3, 2019: 12:15 PM**

**Background.** Prior studies have yielded conflicting findings regarding outcomes for MRSA vs. MSSA infective endocarditis (IE). Our experience suggests that MSSA IE is not any less severe than MRSA IE. The purpose of this study was to compare survival in MSSA and MRSA IE.

**Methods.** Episodes of IE caused by *Staphylococcus aureus* were identified from the Cleveland Clinic Infective Endocarditis Registry. Only the first episode was included for each patient. Acceptance for surgery was considered surgical treatment. Survival from the surgical decision date was compared for MSSA vs. MRSA endocarditis using multivariable Cox proportional hazards regression. Selection of variables for the model was done by stepwise backward elimination from a collection of clinically important baseline variables.

**Results.** Between January 1, 2008 and January 1, 2010, 76 episodes of IE caused by *S. aureus* were identified. The mean (SD) patient age was 58 (15) years, 46 (61%) were males, 14 (18%) had a prior history of IE, 33 (43%) had diabetes mellitus, 22 (29%) had end-stage renal disease (ESRD), 27 (36%) had prosthetic valve endocarditis (PVE), 70 (92%) had left side involvement, 27 (36%) had invasive disease, 59 (78%) were referred patients, and 39 (51%) were treated surgically. The mean (SD) time to decision on surgery was 6 (7) days. Of these episodes 40 (53%) had MSSA IE and 36 (47%) had MRSA IE. There was no difference in hazard of death between MSSA and MRSA IE (HR 0.98, 95% C.I. 0.54–1.78, P-value 0.96), after adjusting for age, ESRD, prior history of IE, PVE, invasive disease, calendar year, and surgical treatment, which were the significant explanatory variables in the multivariable analysis. Survivals predicted by the model for a reference patient with MSSA IE and MRSA IE are shown in the figure.

**Conclusion.** Preliminary findings suggest that survival in MSSA IE may be similar to that in MRSA IE. The study is limited by its small sample size. The study finding will need confirmation with a larger sample.

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**194. Description of Positive Blood Culture Results not Identified by Verigene Informs Empiric Antibiotic Selection**

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Session: 37. Bacteremia, CLABSI, and Endovascular Infections
Thursday, October 3, 2019: 12:15 PM

Background. Bloodstream infections are a leading cause of mortality among hospitalized patients. Optimizing time to pathogen identification and receipt of appropriate antibiotic therapy significantly decreases mortality, morbidity, and length of hospitalization. Rapid diagnostic tests, such as Verigene, assist in the early identification of bacteria and resistance determinants from positive blood cultures; however, Verigene assays are limited to the detection of 13 gram-positive and 9 gram-negative bacteria.

Methods. The purpose of this study was to describe gram-negative and gram-positive aerobic bacteria identified from positive blood cultures with no Verigene target detected and to use the susceptibilities to create an antibiogram to assist in empirical antibiotic selection. A total of 2325 cultures resulted between January 2017 and October 2018 underwent Verigene testing.

Results. Of the 2325 isolates, 383 (16.5%), had no Verigene organism or resistance mechanism detected. Of these, there were 239 (62.4%) gram-positive isolates, 141 (36.8%) gram-negative isolates, and 3 yeast isolates with 96 unique organisms. Seventy-six (19.8%) of the organisms identified by standard culture, but not Verigene testing, are included on Verigene panel. We analyzed nine common antibiotics active against gram-negative organisms to determine percent susceptibilities against the isolated antibiotic: amikacin (92.1%), cefepime (93.5%), cefazidime (94.0%), ceftriaxone (79.7%), ciprofloxacin (88.5%), gentamicin (91.9%), levofloxacin (86.9%), piperacillin–tazobactam (83.8%), and tobramycin (85.5%). Additionally, four antibiotics active against gram-positive organisms were analyzed for gram-positive susceptibilities: cefotaxime (91.6%), ceftriaxone (98.1%), levofloxacin (82.5%), and vancomycin (91.8%).

Conclusion. The results of this study provide clinicians with antibiotic susceptibilities against organisms that were not identified through Verigene testing to guide timely and appropriate antibiotic therapy against gram-negative and gram-positive aerobic bacteria.

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195. Descriptive Study of the Use of External Cooling Blankets in Hyperthermia
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Session: 37. Bacteremia, CLABSI, and Endovascular Infections
Thursday, October 3, 2019: 12:15 PM

Background. Fever is a beneficial physiologic response to infection and is protective in gram-negative bacteremia and invasive candidiasis. Cooling blankets (CBs) are used in fevers due to a perception of providing symptomatic relief. However, external cooling of septic patients has been shown to be an independent risk factor for mortality and adverse effects. Here, we present a retrospective analysis of CB use in our institution.

Methods. We reviewed electronic medical records of patients aged ≥18 years admitted to a tertiary care hospital between 2015–2017 and in whom a CB was used. Study variables included demographics and clinical characteristics such as infection and fever duration (time of CB start to first defervescence). Correlations between continuous variables were assessed using the Spearman’s rank correlation test and differences in the distribution of continuous variables by groups were assessed using Mann–Whitney U and Kruskal–Wallis tests.

Results. This analysis included 548 patients who used a total of 575 CBs during their stay (272 patients used ≥1 CB). The median age was 61.9 years and 56.9% were male. The most frequent comorbidities were immunocompromised state (40.3%), diabetes mellitus (33.6%) and coronary artery disease (32.3%). Pneumonia was the most common infection within 5 days of CB start (31.9%). Only 174 CBs had a documented discontinuation during hospitalization; for the remaining CBs, such documentation was absent. The median CB duration for these patients was 33.8 h (IQR: 18.0–80.9) while median fever duration was only 21.8 hours (IQR: 6.6–52.2). CB duration was highly correlated with fever duration (r=0.773, p<0.001). Clinical documentation of CB use was poor, only 30.2% recorded a stop time. Documented CB duration exceeded fever duration by more than 1.5 times and led to shivering responses in over 2/3 of patients. These findings suggest that CB use is arbitrary, not in keeping with established protocol or rationale, and its adverse effects may outweigh potential benefits. Their role should be re-evaluated and appropriate institutional protocols formulated.

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196. Impact of BioFire FilmArray® Blood Culture Identification on the Management of Staphylococcus aureus Bacteremia
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Session: 37. Bacteremia, CLABSI, and Endovascular Infections
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Background. Staphylococcus aureus bacteremia (SAB) is associated with 30-day mortality rates that are as high as 20 to 40%. In order to reduce mortality and treatment failures, SAB management should include prompt infectious diseases (ID) consult, repeat blood cultures, source control, intravenous antibiotics for the entirety of treatment, and optimal treatment duration. The objective of this study was to determine the impact of rapid diagnosis and management of SAB on the implementation of these standard of care measures in the management of SAB across a large health system.

Methods. This was an IRB approved, retrospective chart review evaluating the impact of rapid diagnostic testing. A total of 2323 blood cultures from 250 patients admitted to our tertiary care hospital between January 2017 and March 2017 were reviewed for antibiotic management failures, SAB management, and the associations of infections with CB duration.

Results. Of the 2015 patients admitted during the study period, 102 (5%) patients were identified with SAB. Median age was 65.9 years, 56.9% were male, and 63.9% were admitted to a surgical service. Mortality among SAB patients was 6%. Infections had proceeded to infective endocarditis in 5% of patients. Adverse effects of antibiotics were documented in 33% of patients. The rate of appropriate antibiotic therapy translated to an improvement in patient outcomes.

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