Conclusion. GC and CT infections increased between 2013 and 2017 in VA. Although females comprise 10% of the VA population, they proportionally had increased GC and CT positive results. VA providers could improve retesting practices 3–12 months post-infection for patients with GC and/or CT.

Table. Demographic Factors and Repeat Testing in Gonorrhea (GC) and Chlamydia (CT) Infections in VA, January 1, 2013–December 31, 2017.

| Characteristic          | GC+CT | GC CT+ | Ref  |
|-------------------------|-------|-------|------|
| Unique patients tested  | 414,316 | 2,702 (26) | 593 (31) |
| Total positive results  | 10,587 | 4,314 | 7,906 (29) |
| Unique positive patients| 9,149 | 2,702 (26) | 593 (31) |
| Female:male             | 1,109:8,040 | 2,702 (26) | 593 (31) |
| Average age (range)     | 40 (17–87) | 31 (13–88) | 36 (17–84) |

*Overall, VA population is 10% female (www.womenshealth.va.gov).

Any GC/CT test 3–12 months after a positive result.

Figure: Five-Year Trend in Gonorrhea (GC) and Chlamydia (CT) Test Results in VA, January 1, 2013–December 31, 2017.

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1500. At Risk Drinking Is Common Among HIV-Infected Department of Defense (DoD) Beneficiaries But Was Not Associated with Prevalent GC/CT Infections

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Session: 149. Sexually Transmitted Infections

Friday, October 5, 2018: 12:30 PM

Background. At-risk drinking and sexually transmitted infections (STIs) are both common among HIV-infected patients. Nearly 50% of subjects in the US Military Natural History Study (NHS), a cohort of HIV-infected DoD beneficiaries, report alcohol misuse. Nonetheless, few studies have examined whether at-risk drinking, a modifiable risk factor, is associated with STIs in this population. We examined the relationship between alcohol use and prevalent gonorrhea (GC) and chlamydia (CT) infections.

Methods. Consented NHS subjects underwent genitourinary (GU) and extragenital nucleic acid amplification testing (NAAAT) for GC/CT infections and responded to a behavioral survey to describe substance use and sexual risk. At-risk drinking was defined as consumption of >4 drinks/day or 14 drinks/week. Logistic regression was used to examine the association of at-risk drinking and GC/CT infections.

Results. A total of 472 men were included with a median age of 41 years (IQR 31, 51); 44% were African American. Male sexual partners were reported by 90%. At-risk drinking (54%) and having sex while drunk in the last 6 months (21%) was commonly reported. Overall, 15% (n = 70) had either GC or CT infection. With respect to anatomic site, 11% had anorectal infections (GC = 4%; CT = 7%), 5.3% had pharyngeal infection (GC = 3.8%; CT = 1.4%) and, 2.3% had GU infection (GC 0.6%; CT 1.7%). In univariate analysis, younger age, multiple male sexual partners, having sex while drunk, and concurrent partnership were associated with STI diagnosis. In the adjusted model, multiple male partners and concurrent sex remained significant (see table).

Conclusion. At-risk drinking remains common in the NHS; however, it was not associated with GC/CT infections. We observed a high prevalence of GC/CT infection, emphasizing the importance of ongoing screening of this high-risk population. Although strategies to reduce alcohol use are unlikely to reduce STIs in our population, these strategies are necessary to reduce other adverse health consequences associated with alcohol use.

Disclosures. All authors: No reported disclosures.
Background. Up to 44% of women who experience a urinary tract infection (UTI) develop a recurrent infection (rUTI) within one year. Insufficient evidence about risk factors for recurrent limits clinicians’ ability to identify women at risk for rUTI who may benefit from further interventions.

Methods. We conducted a retrospective cohort study of women aged ≥21 years who presented for treatment of a UTI at Oregon Health & Science University ambulatory care clinics between 2011 and 2016. Pregnant women as well as those with a recent urinary catheter, genitourinary (GU) procedure, or hospitalization were excluded. The outcome was defined as the first episode of rUTI within one year of an index UTI. Demographics, biologically relevant comorbidities, and the antibiotic prescribed to treat the index UTI were evaluated as potential risk factors for first rUTI using multivariable logistic regression. A best subsets approach was used to determine the most parsimonious model.

Results. A total of 3,632 patients met inclusion criteria. The mean age of the cohort was 50 ± 20 years and 12% had a diabetes diagnosis. To treat their index UTI, 36% of women were prescribed fluoroquinolones, 33% sulfamethoxazole and/or trimethoprim, and 25% nitrofurantoin. Over the study period, the cumulative incidence of first rUTI was 16% (95% confidence interval: [15.3%, 17.7%]); 35% (95% CI: 31%, 39%) of these patients had >1 rUTI. Our model identified age (Odds ratio (OR): 1.02; 95% CI: 1.01, 1.03), urban residence (OR: 1.78; 95% CI: 1.28, 2.57), and a urologic disease diagnosis (OR: 1.46; 95% CI: 1.13, 1.89) affecting GU function (e.g., multiple sclerosis or spinal cord injury) as significant, independent risk factors of first rUTI after adjusting for the confounding effects of diabetes, obesity, and history of stroke, other cerebrovascular disease.

Conclusion. Diagnosis of neurologic disease that impacts GU function, age, and urban residence were identified as significant risk factors for first rUTI. The antibiotic selected to treat patients’ index UTI was not a significant risk factor for first rUTI. Future studies are needed to identify risk factors beyond what is currently captured discretely in the electronic health record to address critical gaps in our understanding of risk factors for rUTI.

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1503. No Benefit to Treating Male UTI for Longer Than 7 Days: An Outpatient Database Study
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Session: 150. Urinary Tract Infection
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Background. The optimal approach for treating outpatient male urinary tract infections (UTI) is unclear. We studied the current management of male UTI in private outpatient clinics, and evaluated antibiotic choice, treatment duration, and the outcome of recurrence of UTI.

Methods. Visits for all male patients 18 years of age and older during 2011–2015 with ICD-9 Codes for UTI or associated symptoms were extracted from the EPCIC Clarity Database of two family medicine, two urology and one internal medicine clinics. For each eligible visit in which an antibiotic was prescribed, we extracted data on the antibiotic used, the duration of treatment, recurrent UTI episodes, as well as patient medical and surgical history. Urogynecologic anatomic abnormalities were an exclusion criterion (Figure 1).

Results. Six hundred thirty-seven eligible visits were included for 573 unique patients (mean age 57.0 ± 16.7 years). Fluoroquinolones (FQs) were the most commonly prescribed class of antibiotic (69.7%), followed by trimethoprim-sulfamethoxazole (TMP-SMX) (21.2%), nitrofurantoin (5.3%) and β-lactams (3.8%). Use of antibiotics was influenced by patient age and comorbidities, while treatment duration was longer for patients with higher important comorbidities.

Conclusion. Men with UTIs are most frequently prescribed FQs. Providers’ choice of antibiotic was influenced by patient age and comorbidities, while treatment duration was influenced by presence of complicating factors.