Table 5. Cure among patients treated with clinical infection

| Characteristic      | Cure (n=42) | No Cure (n=47) | P-value |
|---------------------|-------------|----------------|---------|
| Age (years), median (IQR) | 65 (49-84) | 67 (56-87) | 0.2685 |
| Male sex, n (%)    | 57 (14)    | 27 (34)      | 0.1055 |
| Creatinine, median (IQR) | 10 (10-12) | 4 (0-16)    | 0.0498 |
| Pulmonary source, n (%) | 20 (90)    | 30 (70)     | 0.0001 |
| MAC, n (%)          | 13 (33)    | 20 (27)      | 0.9612 |

Conclusion. NTM infections represent a therapeutic challenge with low cure rates and high mortality. An understanding of the risk factors, treatment options and outcomes is essential to guide appropriate management. Our study highlights high rates of adverse effects and discontinuation which precludes prolonged courses of therapy required to achieve cure.

Disclosures. All Authors: No reported disclosures

1404. Tuberculosis and HIV Coinfection: A Review of 135 Cases Experience of the Infectious Diseases Department, CHU Mohamed VI- Marrakech

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Session: P-80. Tuberculosis and other Mycobacterial Infections

Background. Tuberculosis remains a common disease among which the spine is the most affected site. Less frequently, sacroiliac joint is involved. Its diagnosis is often delayed due to misleading and varied symptoms. The aim of this study was to study the clinical features and the contribution of imaging results in the diagnosis of tuberculosis sacroiliitis.

Methods. We conducted a retrospective study including all patients hospitalized in the infectious disease department for tuberculosis sacroiliitis. The diagnosis was confirmed by pathologic examination of surgical biopsy or biopsy of the sacroiliac area (100%). All patients received antitubercular therapy. Percutaneous abscess drainage was indicated in 4 cases (33.3%). Magnetic resonance imaging was performed in 4 cases (33.3%). Sacroiliac joint was hypointense in T2 weighted images (83.3%) and osteolysis (58.3%). Soft tissue abscesses were noted in 66.7% of the cases. Magnetic resonance scan revealed joint space widening (83.3%), peripheral joint erosions (83.3%) and soft tissues abscess puncture (16.6%) were performed. Computed tomography scan revealed joint space widening (83.3%), peripheral joint erosions (83.3%) and osteolysis (58.3%). Soft tissue abscesses were noted in 66.7% of the cases. Magnetic resonance imaging was performed in 4 cases (33.3%). Sacroiliac joint was hypointense in T1 weighted images (50%), hyperintense in T2 weighted images (50%) and in STIR images (50%). Bone scintigraphy, performed in 5 cases, revealed hyperfixation of the sacroiliac area (100%). All patients received antitubercular therapy. Percutaneous abscess drainage was indicated in 4 cases (33.3%).

Conclusion. Because of its deep localization, the diagnosis of tuberculosis sacroiliitis is mainly based on imaging results associated with epidemiological, clinical and laboratory features. Antitubercular therapy initiated promptly leads to recovery.

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1405. The Accuracy of Mycobacterium tuberculosis Specific IFN-γ/IL-2/TFN-α Fluorospot Test in Differential Diagnosis of Active Tuberculosis and Latent Tuberculosis Infection: A Case-Control Study

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Session: P-80. Tuberculosis and other Mycobacterial Infections

Background. To establish the Mycobacterium tuberculosis (MTB) specific IFN-γ/IL-2/TFN-α Fluorospot assay, and preliminarily evaluate its accuracy of differential diagnosis of active tuberculosis (ATB) and latent tuberculosis infection (LTBI).

Methods. Patients with pathologically confirmed and clinically diagnosed ATB in Peking Union Medical College Hospital and Beijing Chest Hospital from April 2020 to May 2021 were enrolled as case group, while patients with LTBI in the same period were enrolled as control group. The Fluorospot assay was used to simultaneously detect the secretion of IFN-γ, IL-2 and TFN-α in T cells stimulated by the MTB specific antigens ESAT-6 and CFP-10 at the single-cell level. A binary logistic regression model was used to fit the combined diagnostic parameters, and the sensitivity, specificity, predictive value and likelihood ratio of the differential diagnosis of ATB and LTBI were calculated.

Figure 1. Schematic diagram of Fluorospot (IFN-γ/IL-2/TFN-α) detecting cytokine-secreting specific T cells after stimulation with MTB specific antigen. A. The green spots are the total IFN-γ-secreting T cells; B. The red spots are the total IL-2-secreting T cells; C. The blue spots are the total TFN-α-secreting T cells; D. The green spots are the single IFN-γ-secreting T cells; the red spots are the single IL-2-secreting T cells; the blue spots are the single TFN-α-secreting T cells; the yellow spots are the dual IFN-γ/IL-2-secreting T cells; the cyan spots are the dual IFN-γ/TFN-α-secreting T cells; the purple spots are the dual IL-2/TFN-α-secreting T cells; the white spots are the triple IFN-γ/IL-2/TFN-α-secreting T cells.

Results. 62 patients with ATB (37 pathogen-confirmed ATB, 25 clinical diagnosed ATB), 87 patients with LTBI were included. There was significant correlation of the frequencies of total IFN-γ-secreting T cells detected by IFN-γ/IL-2/TFN-α Fluorospot assay compared with T-Spot.TB after stimulation of MTB-specific antigen (r=0.829 for ESAT-6, P<0.001, r=0.804 for CFP-10, P<0.001). ROC curve was drawn for both T-Spot.TB and Fluorospot. For T-Spot.TB, the AUROC was 0.669 (95%CI 0.574-0.765), the sensitivity and specificity of differentiating ATB from LTBI were 58.3% and 95.9%, respectively. The sensitivity and specificity of Fluorospot were 57.3% and 95.6%, respectively. The area under the curve was 0.90 (95%CI 0.828-0.971) for Fluorospot.

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