of piped water in El Salvador is by the ‘Administracion Nacional de Acueductos y Alcantarillados’ (ANDA) agency in EL Salvador, contracted decentralized operators, and/or non-decentralized operators. Descriptive statistics was done to understand the study population and logistic regression was conducted to determine the association between STHI infection and drinking water supply in the study population.

Methods. Of 1310 children, 49.0% (n = 642) were male and 50.6% (n = 399) were 8 year olds. The prevalence of STHI infections in the study population was 2.75% for Ascaris lumbricoides, 4.10% for Trichuris trichiura, and 1.83% for hookworm. Source of drinking water supply was significantly associated with STHI infection in the study population compared with individuals who resided in areas supplied by ANDA, individuals who resided in areas supplied by the decentralized operators under contract management, the risk of infection was 2.8 times higher than amongst those who resided in areas receiving drinking water through piped supply by decentralized operators not under contract management.

Conclusion. Our results show that there is a significant association between the piped drinking water supply and Ascaris lumbricoides infection in the study population.

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288. Community Health Workers Can Strengthen Isoniazid Preventive Therapy Implementation in Rural KwaZulu-Natal, South Africa

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Background. Tuberculosis (TB) remains one of the top 10 causes of death globally, and countries endemic to HIV-TB co-infection are struggling with a growing TB burden in their populations. The highest TB incidence rate in the world is at 834/100,000 and 60% of TB cases are confirmed. The WHO highlights isoniazid preventive therapy (IPT) as a major strategy to combat HIV-associated TB. Community health workers (CHWs) have been utilized in the differentiated care models for HIV treatment programs; pilots have shown their efficacy in screening for TB. No studies have evaluated CHW’s role in implementing IPT. This study explores the potential role of CHWs in expanding IPT in rural KwaZulu-Natal, South Africa.

Methods. The study was conducted in the Msinga sub-district where CHWs were provided training in multidisease screening including HIV, TB, hypertension, and diabetes mellitus, and educated on the nuances of IPT eligibility. CHWs screened up to 30 individuals a month. The primary outcome was the proportion of patients who were HIV(+), TB(−), and not currently on IPT. The secondary outcomes included the percentage of those referred for IPT that were linked to care and the percent initiated on IPT.

Results. Among 1279 individuals screened for HIV and TB December 2015–September 2016, 213 (16.7%) were HIV positive and had a negative TB symptom screen. Of those, 114 (54.5%) were currently on IPT or had been on IPT in the last 12 months and were thus not eligible for preventive treatment. Of the remaining 996 community members eligible for IPT, CHWs referred 46 (46.5%). For those referred, median age was 39 (IQR 30–48) and 91.3% were female. Of those, 29 (63%) linked to care and 32 (67.3%) had referred and 37 (83.7% of those linked to care) initiated IPT.

Conclusion. In rural areas of KwaZulu-Natal, South Africa, CHWs have the capacity to not only screen for infectious and chronic disease, but to simultaneously evaluate for treatment. We quantified the well. Hence, situations with cumulative QTc prolongation by multiple agents, with an arrhythmia warrant a careful medication history and risk assessment in the clinic.

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289. Frequency of Combination Medications Associated with QTc Prolongation in a Travel Clinic

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Background. A common practice during a travel medicine clinic visit is to provide an antibiotic prescription for stand-by treatment of moderate-to-severe traveler’s diarrhea. Ciprofloxacin/levofloxacin or azithromycin are often used for this purpose. These antibiotics have been implicated in prolonging the QTc interval. We quantified the frequency of potential drug-drug interactions in Travel Clinic patients in a retrospective review of a random 3-month cohort of patients who visited our Travel Clinic in 2016. No patients were taking QTc-prolonging medications, and no patient had a pretreatment QTc measurement. We prescribed a combination of QTc-prolonging medications to 23/158 travel clinic patients (14.6%) who were taking antidepressant medications with at least moderate potential for QTc prolongation when combined with a quinolone or azithromycin. An additional nine patients (5.7%) were prescribed multiple other agents with QTc prolongation potential at the conclusion of their Travel Clinic visit. An EKG for risk assessment was recommended by the Travel Clinic provider for seven patients (4.4%).

Conclusion. Travel Clinic patients often are prescribed medications that may enhance the QTc prolongation potential of antibiotics used for stand-by treatment of traveler’s diarrhea. Possibility of adding drugs to QTc-prolonging medications that could increase risk for an arrhythmia warrant a careful medication history and risk assessment in the clinic.

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290. Clinical and Epidemiological Characteristics of Japanese Spotted Fever and Scrub Typhus in Central Japan, 2004–2015

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Background. Japanese spotted fever (JSF) and scrub typhus (ST) are endemic rickettsial diseases in Japan. Both diseases are transmitted by ticks that can be found in our study area. No studies have specifically compared JSF with ST, we investigated the clinical and epidemiological characteristics of JSF and ST in the area where both are endemic.

Methods. We systematically collected clinical and epidemiological data from all patients diagnosed with JSF and ST in central Japan. A total of 616 patients were enrolled, 44% were female, and the mean age was 64 years. Thirty-two patients were diagnosed as JSF, 204 were ST, and 97 were non-rickettsial diseases. Only one patient died of ST. Comparing to non-rickettsial diseases, patients with JSF and ST were significantly older, and more of them resided in wooded areas (P < 0.001). Spatial clusters were identified for both JSF (P < 0.001) and ST (P < 0.05). JSF occurred from April to October with a small peak in July, while 90.2% of ST was diagnosed in November and December. Both rash and eschar were detected in the majority of JSF (97%, 86%) and ST (96%, 87%). When compared with ST, purpura, and the rash on palms/soles were strongly associated with JSF (OR, 29.0, 61.1, respectively). However, patients were much less likely to complain their rash (27% JSF; 44% ST) and eschar (0% JSF; 2.5% ST). Moreover, 26% of JSF and 28% of ST cases did not present with apparent fever (≥37.5°C). All identified ST strains were Irie/Kawasaki (16/22, 73%) or Hirano/Kuroki (6/22, 27%).

Conclusion. Although clinical picture of JSF and ST are similar, there are some clues to distinguish JSF from ST such as seasonality, geographical region, rash distribution on palms/soles, and the hemorrhagic nature of rash. Rickettsial cases may be underdiagnosed if clinical diagnosis relies on fever, rash, and eschar.

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291. Clinico-Epidemiological Profile of Adolescent and Adult Patients with Tegumentary Leishmaniasis from the Colombian Southwest 2004–2014

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Background. Tegumentary leishmaniasis. Incomplete or unconfirmed records were excluded. We considered JSF and ST strains to be JSF and ST if patients were diagnosed with either disease in the previous year. JSF occurred from April to October with a small peak in July, while 90.2% of ST was diagnosed in November and December. Both rash and eschar were detected in the majority of JSF (97%, 86%) and ST (96%, 87%). When compared with ST, purpura, and the rash on palms/soles were strongly associated with JSF (OR, 29.0, 61.1, respectively). However, patients were much less likely to complain their rash (27% JSF; 44% ST) and eschar (0% JSF; 2.5% ST). Moreover, 26% of JSF and 28% of ST cases did not present with apparent fever (≥37.5°C). All identified ST strains were Irie/Kawasaki (16/22, 73%) or Hirano/Kuroki (6/22, 27%).

Conclusion. Although clinical picture of JSF and ST are similar, there are some clues to distinguish JSF from ST such as seasonality, geographical region, rash distribution on palms/soles, and the hemorrhagic nature of rash. Rickettsial cases may be underdiagnosed if clinical diagnosis relies on fever, rash, and eschar.

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Methods. A chart review, including medication lists, occurred for 158 consecutive patients who visited our Travel Clinic in a 3-month period. The number of patients taking specified medications with potential for QTc prolongation at the time of their Travel Clinic visit and the frequency of specific agents were tallied. Whether EKGs were recommended was recorded.

Results. 23/158 travel clinic patients (14.6%) were taking antidepressant medications with at least moderate potential for QTc prolongation when combined with a quinolone or azithromycin. An additional nine patients (5.7%) were prescribed multiple other agents with QTc prolongation potential at the conclusion of their Travel Clinic visit. An EKG for risk assessment was recommended by the Travel Clinic provider for seven patients (4.4%).

Conclusion. Travel Clinic patients often are prescribed medications that may enhance the QTc prolongation potential of antibiotics used for stand-by treatment of traveler’s diarrhea. Possibility of adding drugs to QTc-prolonging medications that could increase risk for an arrhythmia warrant a careful medication history and risk assessment in the clinic.

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