of the T2 and BC in Tx and non-Tx patients were compared. BC obtained within 7 days before or after the T2 test were included in the analysis. TAT, sensitivity, specificity, PPV and NPV were calculated using positive BC as the standard. Differences between groups were assessed using two sample proportions testing at α = 0.05.

**Results.** A total of 1,272 patients with suspected candidemia had T2 done: 1,162 (91%) non-Tx and 110 (9%) Tx patients. Average TAT for T2 was 13 hours (5–41) vs. 34 hours (21–109) to initial positive BC result and 4 days (3–13) to species-specific BC result. In four non-Tx patients with negative T2, C. lusitaniae, C. dubliniensis and C. kefyr were isolated in BC. Performance characteristics of T2 and BC in the two groups is shown (Table 2). Of the T2+/BC− cases (n = 103), 9% had retinits and 9% had invasive candidiasis.

**Conclusion.** The rapid TAT, good sensitivity, and high NPV of T2 in Tx patients has clinical implications and can help support antifungal stewardship efforts in this population. The clinical significance of T2 positivity in the presence of negative BC needs further investigation.

**Table 1: Performance Characteristics of T2 Compared with BC (N = 1,272)**

| T2 + and blood culture + | T2 + and blood culture − | T2 - and blood culture + | T2 - and blood culture − |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Tn (n = 110)             | Tn (n = 110)             | Tn (n = 1162)            | Tn (n = 1162)            |
| 5 (4.5%)                 | 35 (3.01%)               | 19 (17.3%)               | 86 (7.4%)                |
| 1 (0.9%)                 | 41 (3.5%)                | 20.8%                    | 28.9%                    |
| Sensitivity              | 83.3%                    | 91.9%                    | 98.8%                    |
| Specificity              | 92.4%                    | 92.4%                    | 96.2%                    |
| PPV                      | 0.003                    | 0.1431                   | 0.3917                   |
| NPV                      | 0.1431                   | 0.1431                   | 0.3917                   |

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1137. Implementation of Universal Screening for Strongyloidiasis Among Solid-Organ and Hematopoietic Stem Cell Transplant Candidates in a Non-endemic Area

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**Session:** 134. Fungi and Parasites in Immunocompromised Patients  
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**Background.** Strongyloidiasis can lead to hyperinfection and disseminated infection after transplantation with significant morbidity and mortality. Treatment for Strongyloidiasis prior to transplantation can reduce the risk of disseminated infection. Targeted screening based on travel history and country of origin incompletely identifies at-risk patients. Data on universal screening prior to solid-organ (SOT) or hematopoietic stem cell transplantation (HSCT) are limited. We implemented universal serology-based screening for strongyloides at our transplant center, located in a metropolitan non-endemic area.

**Methods.** We identified patients screened with serum Strongyloides IgG by ELISA during pre-transplant evaluation for SOT or HSCT from August 1, 2017 to April 25, 2018. We reviewed adherence to the screening recommendation by program type and the medical record of seropositive patients for country of origin, history of eosinophilia (>500 cell/μL), Gram-negative bacteremia, ova and parasite (O&P) examination and treatment.

**Results.** A total of 812 patients were evaluated for transplantation during the study period: 484 for kidney, 152 for liver, 20 for liver/kidney transplant, 40 for heart, 24 for lung, and 100 for HSCT. 201 (24.7%) of the 812 patients were screened for Strongyloides; 107 (17%) evaluated for abdominal transplant, 32 (50%) for thoracic transplant, and 62 (60%) for HSCT. Seventeen (8.4%) of 201 patients screened tested positive: nine evaluated for kidney transplant, four for heart, one for liver, and three for HSCT. Nine of 17 patients (53%) were treated with Ivermectin or referred to Infectious Diseases clinic prior to our review. Ten (59%) seropositive patients were from the United States and travel had no documented travel to endemic areas; six patients were from countries other than the United States; and one from Puerto Rico. Two patients with Strongyloidiasis had eosinophilia, one had history of Klebsiella pneumoniae bacteremia and one had stool O&P examination. Screening was higher when using an electronic order set (57% vs. 12%).

**Conclusion.** Universal screening for Strongyloidiasis identified individuals with latent infection who did not have epidemiological or clinical findings suggestive of Strongyloidiasis. Screening for Strongyloidiasis was higher in transplant programs that incorporated the recommendation into an electronic order set.

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

1138. Retrospective Cohort Analysis of Amphotericin B Nephrotoxicity in Kidney Transplant Recipients

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**Background.** Amphotericin B (AmB) is a polyene agent widely used for the treatment of invasive fungal infections. The incidence of nephrotoxicity in kidney transplant recipients is not well defined. This study aimed to retrospectively evaluate the incidence of Amphotericin B nephrotoxicity in a cohort of kidney transplant recipients.

**Methods:** A retrospective cohort analysis was conducted using a computerized database at a tertiary hospital in Richmond, Virginia, from 2010 to 2016. All kidney transplant recipients were included and Amphotericin B use was identified. Nephrotoxicity was defined as a ≥50% decrease in estimated glomerular filtration rate (eGFR) or a ≥20% increase in serum creatinine from baseline to the end of treatment. Logistic regression analysis was performed to identify predictors of nephrotoxicity.

**Results:** A total of 174 kidney transplant recipients were identified. Of these, 78 (44.9%) received Amphotericin B. Nephrotoxicity was observed in 18 (23.1%) recipients, including 7 (9.1%) with acute kidney injury (AKI) and 11 (14.1%) with chronic kidney disease (CKD) progression. Significant predictors of nephrotoxicity included higher baseline creatinine, higher dosages of Amphotericin B, and longer duration of treatment. The overall incidence of nephrotoxicity was 23.1% (95% CI: 15.0%–31.7%).

**Conclusion:** The incidence of Amphotericin B nephrotoxicity in kidney transplant recipients was 23.1%. Higher baseline creatinine, higher dosages of Amphotericin B, and longer duration of treatment were significant predictors of nephrotoxicity. Further studies are needed to identify modifiable factors to reduce the incidence of nephrotoxicity.

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