an ABSSSI diagnosis presenting to two academic medical centers in Detroit, MI from 2010 to 2015 were included. Baseline clinical characteristics and outcomes were compared between cases (ABSSSI + BSU) and controls (ABSSSI). Outcomes included in-hospital mortality, hospital length of stay (LOS) and 30-day readmission. Fisher’s exact and Student’s t-test were used for bivariate comparisons. Regression analysis at a P-value ≤ 0.05 were included in multivariable analysis using a stepwise forward method and logistic regression to examine factors independently associated with ABSSSI + BSU.

**Results.**
392 patients consisting of 196 ABSSSI + BSU and 196 controls ABSSSI were evaluated. In bivariate analysis, individuals with ABSSSI + BSU were significantly older (P < 0.001), more likely to be male (P = 0.008), and an intravenous drug user (P = 0.012), have chronic renal failure (P = 0.002), prior hospitalization (P < 0.001), and more systemic symptoms, such as elevated temperature, white blood cell count, and acute renal failure on hospital admission (P < 0.001). By regression, male gender (OR 1.85, 95% CI 1.13-3.66), acute renal failure (OR 2.08; 95% CI 1.18-3.67), intravenous drug use (OR 4.38, 95% CI 2.22-8.62), and prior hospitalization (OR 2.41; 95% CI 1.24-4.93) remained statistically significant. ABSSSI + BSU patients were more likely to experience in-hospital mortality (4.1 vs. 0%, P < 0.001), have longer mean LOS (7.4 ± 5.7 vs. 2.7 ± 2.2 days, P < 0.001), and experience 30-day readmission (11.2 ± 4.1%, P = 0.006).

**Conclusion.**
Patients with ABSSSI + BSU had worse outcomes than those with ABSSSI alone. Factors associated with ABSSSI + BSU, such as gender, IVDU, prior hospitalization, renal failure, and systemic signs/symptoms of infection, may be used to identify patients at risk for ABSSSI + BSU.

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260. Post-Discharge Antibiotic Therapy in Patients with Acute Bacterial Skin and Skin Structure Infections

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**Background.**
There are limited published data regarding the post-discharge treatment for most infections, including acute bacterial skin and skin structure infections (ABSSSIs).

**Methods.**
This is a retrospective study of Veterans Affairs medical center admissions with diagnosis codes for ABSSSIs between January 1, 2005 and September 30, 2015. Patients receiving vancomycin during this admission were selected for inclusion. Treatment approaches after hospital discharge, including oral antibiotics, as well as intravenous (IV) medications administered in an outpatient clinic were assessed. Differences between oral and IV groups were assessed with a P-value ≤ 0.05). In unadjusted comparisons between the oral and IV groups, the following additional 15% had loss of an organ). Those with MDRO were more likely to experience complications, and outcome. Descriptive and univariate statistics were performed.

**Results.**
Of the 118,135 ABSSSI admissions, 114,352 (96.8%) patients continued antibiotic therapy after discharge. Most patients (98.5%) continued on oral therapy (median length of stay 4 days vs 6 days in IV group; P < 0.05). The most common oral therapies after discharge were sulfamethoxazole/trimethoprim (n = 30,220, 26.8%) and amoxicillin clavulanate (n = 21,819, 19.4%). The most common IV antibiotics were vancomycin (n = 740, 57.5%) and ceftiraxone (n = 220, 17.1%). Significant differences in demographics, medical conditions, and resistance patterns were observed between the oral and IV groups; however, absolute differences were negligible in some cases (e.g., median age 61 in oral group and 62 in IV group). Differences between oral and IV groups, the following day and every 72 hours if urine cultures remained positive. If significant pyuria persisted, urine cultures were performed weekly. Treatment responses were assessed using the National Tuberculosis Surveillance System criteria.

**Conclusion.**
Most patients with ABSSSI admissions continued antibiotic therapy after discharge, with only 1.1% receiving IV antibiotics in an outpatient clinic after discharge. Demographic characteristics and morbidity burden were similar between the oral and IV groups; however, small absolute differences were statistically significant as this was a large study.

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261. Evaluation of Dalbavancin and Oritavancin as Cost-Effective Treatments of Acute Bacterial Skin and Skin Structure Infections in Hospitalized Patients

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**Background.**
Acute bacterial skin and skin structure infections (ABSSSI) are a challenging medical problem associated with high health care costs. Dalbavancin and oritavancin are approved for treatment of ABSSSI and, due to their long half-life, are dosed as a one-time infusion. These agents may make it possible to allow for earlier discharge and reduce health care costs without compromising efficacy.

A retrospective cost analysis at a single academic medical center was performed using patient data from patients discharged from AbbVie NorthWestern Hospital (ANW) with primary diagnosis of skin and soft-tissue infection between October 1, 2015 and September 30, 2016. Inclusion and exclusion criteria were approved by ANW Antimicrobial Stewardship Committee and used to retrospectively identify potential candidates for oritavancin or dalbavancin. Retrospective cost-analysis was performed to assess potential cost savings with the use of dalbavancin or oritavancin instead of the traditional antibiotic therapy that was used. Financial impact was assessed taking into consideration potential cost savings and additional expenses with the use of daptomycin or oritavancin. Data are presented as mean ± standard deviation. Statistical comparison between actual and predicted length of hospital stay was performed using paired t-test. P < 0.05 was considered statistically significant.

**Results.**
In total, 294 admissions were identified. Eight patients met the selection criteria with the majority being intravenous drug users. Actual length of stay of candidates for dalbavancin or oritavancin was 4.3 ± 2.8 days. Predicted length of hospital stay if dalbavancin or oritavancin were used was 3.0 ± 1.9 days (P = 0.03 vs. actual length of stay). The use of dalbavancin or oritavancin may have prevented four readmissions, (P = 0.48); of note most (83%) of stated savings derived from patients discharged from ANW.

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262. Emergence of Multi-Drug-Resistant Organisms (MDROs) Causing Fournier’s Gangrene

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**Background.**
Fournier’s gangrene is an uncommon but often devastating infection. There are few contemporary data on the risk factors and evolving microbiologic trends including emergence of emerging resistant organisms implicated in these life-threatening infections.

**Methods.**
A retrospective study of Fournier’s gangrene from 2006 to 2015 at a large academic hospital was conducted. Cases were identified using ICD codes (ICD-9: 880.60; 813.89; ICD-10: N49.3, Z87.438), and a review of medical and pathology records was performed to confirm each case. Data collected included socio-demographic, medical conditions, bacterial pathogens and their resistance patterns, treatment, and outcome. Descriptive and univariate statistics were performed.

**Results.**
In total, 59 cases were evaluated with an incidence of 31.8 cases per 100,000 admissions over the study period. Mean age was 56 years (range 18–91), 71% were male, and 45% were HIV positive. The mean A1c of 9.6%. Other risk factors included: overweight/obesity (61%), immunocompromised state (34%), and substance use (32%). A caustive organism was identified in all but two cases; 12 patients (21%) had an MDRO with MRSA being the most common pathogen (n = 8, 14% of all cases), followed by ESBL (n = 3) and MDRO Acinetobacter (n = 1). MRSA was the sole pathogen in five (63%) of the eight cases involving this organism. Among those with an aerobic Gram-negative rod (GNR) isolated, 31% were fluoroquinolone-resistant. An MDRO infection was significantly associated with a mortality rate of 3.8% (95% CI 0.3–3.0%) (OR 0.70, P = 0.02). Overall, 30% of all cases had an adverse outcome (15% died and an additional 15% had loss of an organ). Those with MDRO were more likely to experience an adverse outcome (24% vs. 28%), although this was not statistically significant (P = 0.48) of note most (83%) MDRO cases were treated with an initial antibiotic with efficacy against the MDRO. Conclusion.

**Conclusion.**
This report suggests a much higher incidence of Fournier’s gangrene than previously described and highlights the emergence of MDROs as an important cause of acute skin and soft-tissue infections including Fournier’s gangrene.

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