Background. Ceftedorol is a siderophore cephalosporin discovered by Shionogi & Co., Ltd., which exhibits potent efficacy against Gram-negative carbapenem-resistant bacteria. Pediatric clinical studies are planned. Ceftedorol is mainly renally eliminated. A 2-g infusion of ceftedorol over 3 hours, every 8 hours (q8h) is the recommended dose regimen in adults. In this study, dose regimens for pediatric subjects (births to <18 years old) are proposed based on predictions of pharmacokinetics (PK) in pediatrics using data from adults to provide adequate exposure.

Methods. The PK model developed based on data in adults was modified for predicting PK in pediatrics. Total clearance and volume of distribution at steady state in pediatrics were scaled using allometric relationships developed for parental β-lactam antibiotics. The maturation factor of renal function was also incorporated into the model to predict PK in neonates and infants whose glomeruli are immature. The dose was selected to provide area under the concentration curve (AUC) comparable to adults. Monte-Carlo simulations were performed to calculate probability of target attainment (PTA) for 75% of fraction of time during which the free plasma concentrations exceed the minimum inhibitory concentration (MIC) over the dosing interval (T_dos) for age groups at the proposed doses against an MIC range from 0.25 to 16 µg/mL.

Results. The dose regimens for pediatrics were proposed based on age and body weight as shown in the table below. The dose of 60 mg/kg (maximum 2 g) q8h was selected as a standard dose. The dose for pediatrics aged <3 months was adjusted based on age. AUC predicted in pediatrics from birth to <18 years old for the proposed dose was comparable to that observed in adults. The proposed dose provided >90% PTA for 75% T_dos against MICs up to 4 µg/mL.

Table. Proposed Doses of Ceftedorol for Pediatric Subjects

| Age Group | Proposed Dose | Body Weight (kg) |
|-----------|---------------|------------------|
| <2 months | 30 mg/kg q8h | >34 kg |
| 2-<3 months | 40 mg/kg q8h | >50 mg/kg |
| 3 months to <18 years | 60 mg/kg q8h | >45 kg |
| Dosing: 3x daily (i.e., 2.5 mg/kg for <3 months, q8h) |

Conclusion. The proposed dose regimens provide comparable (to adults) exposure in pediatric patients for target carbapenem-nonsusceptible pathogens, 98% of which are susceptible to cefiderocol at a MIC of ≤4 µg/mL.

Disclosures. All authors: No reported disclosures.

741. Tramvl Surveillance of Travel-Related Illness in a Prospective Cohort of US Military Beneficiaries, 2010–2018
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Background. Increasing international travel places larger populations at risk for infections outside of their usual exposure. Deployed military personnel have unique risks for such infections. Our cohort’s rates of travelers’ diarrhea and influenza-like illness have been defined, but the rate of travelers with symptoms apart from a clinical syndrome has not. We present a survey of intra-travel symptoms of all travelers and confirmed diagnoses of ill-returned travelers in a cohort of military and civilian travelers.

Methods. TramVL is a prospective, multicenter observational study enrolling US military beneficiaries traveling outside the continental United States from 2010–2018; beneficiaries could also enroll after travel if they presented for a possible travel-related illness. Demographic information, intra-travel symptoms, and confirmed diagnoses were recorded.

Results. 2671 travelers embarked on 3050 trips; 63.1% male; median age 38 years (IQR 27, 57); median trip duration 20 days (IQR 13, 46). Common purposes of travel: military deployment (45.9%), vacation (23.7%), and visiting friends/relatives (10.9%). Ninety-seven travelers (3.2%) enrolled post-travel. Top regions of travel: Africa (31.5%), South and Central America/Caribbean (25.5%), and Southeast and North Asia/Oceania (19.4%). During travel, 56.6% experienced gastrointestinal (GI) symptoms, 11.9% respiratory symptoms, and 3.0% fever; of those, 10.3% sought medical care. Eighty travelers returned (19.4%). During travel, 56.6% experienced gastrointestinal (GI) symptoms, and 3.0% fever; of those, 10.3% sought medical care. Eighty returned travelers sought medical care (21 prospective enrollees vs. 59 post-travel enrollees): 5 vs. 17 malaria cases, 3 vs. 16 arbovirus infections, and 6 vs. 14 GI syndromes. All malaria cases in prospective enrollees were in military subjects. Post-travel enrollees accounted for 1 acute human immunodeficiency virus and 3 rickettsial infections.

Conclusion. A majority of our travelers experienced symptoms during travel. Post-travel diagnoses, although uncommon, emphasize needed improvements in the application of known risk mitigation strategies. Our findings can help clinicians optimize their pretravel counseling by focusing education on self-treatment of common travel-related symptoms, prevention of GI, arthropod-borne, and respiratory illness, and emphasizing symptoms that should prompt medical care.

Disclosures. All authors: No reported disclosures.

742. The Development, Implementation, and Feasibility of Multidisciplinary Treatment Planning Conference for Individuals with Unstable Substance Use Disorders and Active Infections Requiring Prolonged Antimicrobial Therapy: The OPTIONS-DC Model
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Background. Outpatient parenteral antimicrobial therapy (OPAT), widely used for serious infections, has high failure rates in people with substance use disorders (SUD)\(^1\)\(^2\). At our institution, completing therapy in the hospital was previously the best option for high-risk patients; but long hospital stays are often unacceptable to patients and costly. To improve outcomes, our Infectious Diseases division, OPAT program, and Improving Access to Care Team (IMPACT) developed and implemented a novel multidisciplinary conference (OPTIONS-DC) for inpatients with SUD requiring prolonged antibiotics. This study describes the conference development, tool, and initial experience.

Methods. From June 2017 to June 2018, diverse stakeholders collaboratively created and implemented a structured conference to discuss treatment options that balance medical efficacy, patient preferences, and feasibility using harm-reduction principles. After 10 months of hospital-wide implementation, we elicited provider feedback and performed a content analysis of OPTIONS-DC notes and patient records to evaluate the impact.

Results. The goal of conference development was prioritizing patient preferences and engaging multidisciplinary input. One RN facilitates the conference using the tool (Figure 1) to elicit input from the relevant providers. The tool systematically addresses components that may predict treatment success (i.e., working phone) while emphasizing patient preference and harm reduction. The IMPACT social work PICC safety assessment informs risks for IV access. Antibiotic recommendations are not a binary of optimal/suboptimal choices for the infection but options that best fit patient context. The average conference length was 28 minutes (IQR 21). Preliminary data shows good clinical outcomes and savings to inpatient days and cost. Initial feedback suggests the model was positively experienced by medical providers (Figure 2) and supported patient preferences.

Conclusion. A multidisciplinary patient-centered conference that prioritizes patient preference and uses harm-reduction principles for this high-risk population is practical, effective, and positively experienced by providers. This model may serve as a roadmap for other institutions.

**Figure 1.** Cumulative risk of ADR among OPAT patients initiated on beta-lactam therapy, 2015-2018.

**Table 1: ADRs per specific therapy**

**Figure 2:** Provider Feedback on Conference Model (n=30)

374. Evaluation of Adverse Drug Reactions due to Common \(\beta\)-Lactam Therapies Among Patients Enrolled in an Outpatient Parenteral Antimicrobial Therapy (OPAT) Program

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**Background.** The UNC Medical Center Outpatient Parenteral Antimicrobial Therapy (OPAT) program was started in 2015 to provide multidisciplinary monitoring and management of patients discharged on parenteral antimicrobials. Laboratory abnormalities and adverse drug reactions (ADRs) are potential complications of OPAT that may result in readmission and treatment changes. The purpose of this study was to evaluate the time to first ADR for OPAT patients treated with BL therapies for diabetic foot infections (DFI) and osteomyelitis (OM).

**Methods.** This was a retrospective cohort study of patients enrolled in the UNC OPAT program between January 2015 and September 2018 for treatment of DFI or OM. Included patients received one of the following: BL cephalosporin, ceftriaxone, ertapenem, meropenem, and piperacillin/tazobactam. The primary outcome was time to first ADR during OPAT. Secondary outcomes were estimation of risk of ADR during OPAT for each medication; and ADR types and frequencies observed among patients treated with BL alone or with concomitant vancomycin or daptomycin.

**Results.** In this cohort, 178 OPAT patients received 193 OPAT courses, for a median duration of 42 days (IQR 38–50). The average patient age was 55 years, and 68% were male. Ertapenem was the most commonly prescribed BL (76 courses, 39%), followed by ceftriaxone (29, 15%), cefepime (41, 21%), piperacillin/tazobactam (30, 16%) and meropenem (17, 9%). Approximately 40% (76) patients received concomitant vancomycin. ADR was documented in 48 patients (27%) and 56 courses of therapy (29%). Kaplan–Meier–estimated risk of at least one ADR in the first 8 weeks of therapy was 38.7% (95% CI 29.1% to 48.2%). ADR resulted in 32 therapy changes and 8 readmissions.

**Conclusion.** More than one-third of patients treated with BL for treatment of DFI and/or OM are at risk of ADR within 8 weeks. ADR commonly resulted in treatment changes, and possible hospital readmission. BL therapy is associated with significant ADR risk, and careful selection and monitoring is essential for optimal patient safety during OPAT.

**Figure 2:** Provider Feedback on Conference Model (n=30)

374. Antifungal De-escalation Strategy in ICU Patients: Clinical Success and Cost Savings

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