and was treated 74.6% of the time (Figure 3). Significant risk factors for MDR UTI included female gender ($P = 0.005$), IV abx ($P = 0.001$), and recurrent UTI ($P = 0.017$).

**Conclusion.** Incidence of symptomatic UTI at our center was lower than previous reports. *E. coli* and *E. faecalis* were the most common urinary pathogens identified. MDR risk factors identified were biologically plausible and consistent with prior literature. ASB treatment occurred frequently and is an area to target stewardship interventions.

**Figure 1:** Bacteriuria Adjudication

| Urine culture with ≥10^5 CFU/mL |
|----------------------------------|
| UTI                              |
| No symptoms                      |
| Lower symptoms                   |
| Flank pain or Fever              |

**Figure 2:** Microbiologic and Susceptibility Results

| Cultures with ≥10^5 CFU/mL | <10^5 CFU/mL |
|-----------------------------|--------------|
| UTI                         | UTI          |
| Asymptomatic bacteriuria    | UTI          |
| Cystitis                    | UTI          |
| Pyelonephritis              | UTI          |

**Results.** A total of 296 patients with median age of 83 (range 49–97) underwent TAVR. Two hundred and sixty UAs with reflex to culture (137 of which reflected) and eight additional urine cultures (UC) were sent. One hundred and thirty-three of 145 UC (91%) had documented symptoms. There were 44 patients with positive UC, of which nine (20%) had symptoms. Of the 35 with ASB, 27 received antibiotics prior to TAVR (77%). Among those who were treated, there was one case of C. diff, three cases of development of resistance in an organism previously isolated and three cases of newly acquired MDRO. This amounts to a number needed to harm of 3.86. There were no cases of any of these outcomes, 30-day readmission or death within 90 days for the ASB patients who did not receive treatment. In the treatment group, there was one case of bacteria for which the causative organism was different from the organism isolated in UC.

**Conclusion.** In this small cohort of mostly elderly TAVR patients, the rate of ASB was high as expected and most were treated. We documented cases of potential harm associated with antibiotic treatment, and found no such harm episodes in the untreated group. Given the high number needed to harm and the historically low risk of PVE, antimicrobial stewardship experts should continue to encourage avoidance of antibiotics for ASB, including for patients undergoing invasive and minimally invasive cardiac procedures.

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

1510. Treatment of Asymptomatic Bacteriuria prior to Transcatheter Aortic Valve Replacement

Alexandra Clay, BA1; Kirthana R. Beaulac, PharmD2; Gabriela M Andujar Vazquez, MD3; Shira Doron, MD, MS, FIDSAP4 and David Snidman, MD, FIDSA5; Geographic Medicine and Infectious Diseases, Tufts Medical Center, Boston, Massachusetts; Department of Pharmacy, Tufts Med. Ctr., Boston, Massachusetts, 6Division of Geographic Medicine and Infectious Diseases, Tufts Medical Center, Boston, Massachusetts

**Session:** 150. Urinary Tract Infection

**Friday, October 5, 2018: 12:30 PM**

**Background.** Based on large population-based studies, the risk of prosthetic valve endocarditis (PVE) after surgical aortic valve replacement is 0.57% per person year. There is no causal link from asymptomatic bacteriuria (ASB) to PVE; however, antibiotics are often prescribed in an abundance of caution given the catastrophic downside. The risk of PVE is yet to be determined in patients who receive a transcatheter aortic valve replacement (TAVR), but likely lower due to the minimally invasive approach. At our institution, ASB is heterogeneously treated with antibiotics prior to TAVR. Herein we quantified some untoward outcomes of treatment of ASB pre-TAVR.

**Methods.** A single-center retrospective study was conducted for patients who underwent TAVR between October 2012 and June 2017. Pre- and post-procedural urinalyses (UA), culture results, antibiotic regimens, development of resistance, symptoms of UTI, 30-day readmission rates, and 30- and 90-day mortality rates were collected.

**Results.** A total of 296 patients with median age of 83 (range 49–97) underwent TAVR. Two hundred and sixty UAs with reflex to culture (137 of which reflected) and eight additional urine cultures (UC) were sent. One hundred and thirty-three of 145 UC (91%) had documented symptoms. There were 44 patients with positive UC, of which nine (20%) had symptoms. Of the 35 with ASB, 27 received antibiotics prior to TAVR (77%). Among those who were treated, there was one case of C. diff, three cases of development of resistance in an organism previously isolated and three cases of newly acquired MDRO. This amounts to a number needed to harm of 3.86. There were no cases of any of these outcomes, 30-day readmission or death within 90 days for the ASB patients who did not receive treatment. In the treatment group, there was one case of bacteria for which the causative organism was different from the organism isolated in UC.

**Conclusion.** In this small cohort of mostly elderly TAVR patients, the rate of ASB was high as expected and most were treated. We documented cases of potential harm associated with antibiotic treatment, and found no such harm episodes in the untreated group. Given the high number needed to harm and the historically low risk of PVE, antimicrobial stewardship experts should continue to encourage avoidance of antibiotics for ASB, including for patients undergoing invasive and minimally invasive cardiac procedures.

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