Current susceptibility testing recommendations for β-hemolytic streptococci outline testing for clindamycin resistance, including inducible resistance by a positive D-zone phenotype. However, few studies describe the prevalence of clindamycin resistance among invasive GCS and GGS organisms. This study aims to describe the prevalence of clindamycin resistance among GCS/GGS compared with invasive Group A streptococci (GAS) during the same period in a large United States health system.

Methods. Streptococcus isolates from blood, tissue, and body fluids (n = 298) recorded from January 1, 2013 to May 1, 2017 were audited using SafetySurveill" software. Members of the α-streptococcal group streptococci were excluded. Specimens submitted to the clinical microbiology laboratory were grown in 5% CO₂ on colistin-nalidixic acid agar, Mueller-Hinton 5% sheep blood agar, and chocolate agar. Cultures positive for β-hemolytic streptococci were identified to the species level via MALDI-TOF MS. Disk diffusion D-zone testing was performed with 0.5 McFarland standards using erythromycin (15 μg) and clindamycin (2 μg) disks 12 mm apart on Mueller-Hinton 5% sheep blood agar plates incubated at 35°C in 5% CO₂ for 20-24 hours. Susceptibilities to penicillin, erythromycin, clindamycin, and vancomycin were recorded per current CLSI breakpoints.

Results. A total of 128 GAS isolates were tested, of which n = 61 (28.8%) demonstrated clindamycin resistance; 85.2% were clindamycin resistant via a positive D-zone phenotype with 14.8% that were constitutively clindamycin resist- ant. A total of n = 86 GAS isolates were tested, of which n = 9 (10%) demonstrated clindamycin resistance. This study reported clindamycin resistance via a positive D-zone phenotype with 56% which were constitutively clindamycin resistant.

Conclusion. Clindamycin resistance among GCS and GGS was present in 24.5% of the isolates tested with 10% for GAS. As a proportion of the total number of isolates tested, inducible resistance was 14.5% more frequent in among GCS and GGS than was observed for GAS. This study demonstrates a higher proportional level of clindamycin resistance in GCS/GGC compared with GAS infections detected over the same study period.

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2102. Elevated Neutrophil-to-Lymphocyte Ratio is an Effective Prognosis Indicator In Extra-Pulmonary Tuberculosis

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Methods. Data were collected from EPT patients, diagnosed between 1990 and 2016. We defined a PP by the occurrence of clinical complications during the hospital-stay or the follow-up. We evaluated the performance of NLR in identifying PP. The Kaplan-Meier method was used to generate complication-free survival curves which were compared by Log rank test according to NLR categories. Cox proportional hazard regression analysis was used to reveal the independent prognostic factors.

Results. We included 265 patients with EPT among them 68 cases (25.7%) had at least one PP. The mean age was 42 ± 19.2 years. Sex ratio was 0.8. EPT in-criminated lymph node in 95 cases (35.8%), neuromenigal sites in 50 cases (19%) and bones in 42 cases (15.8%). Mean value of NLR was significantly higher in the PP group (4.5 ± 3 vs. 3.2 ± 2.5; P = 0.01). NLR had an Area Under the Receiving Operating Curve (AUROC) of 0.63 in predicting PP (P = 0.04). At an optimal cut-off value of 2.7, sensitivity and specificity were of 60%. There were 128 cases (48.3%) with a high NLR (≥ 2.7). Positive predictive value of NLR was 67.2% while negative predictive value achieved 80%. Overall, the median complication-free survival was 3 days (IC 95% 1.2–4.67). When stratified by NLR cut-off, survival cure analysis showed that the one-month complication-free survival rate was lower in patients with high NLR (45% vs. 55%; P = 0.042). In multivariate Cox regression analysis, high NLR was an independent risk factor of predicting PP in EPT patients (HR = 1.7; 95% CI 1.1–2.9; P = 0.048).

Conclusion. In this study, the elevated neutrophil-to-lymphocyte ratio was a useful prognostic factor to predict complications in patients with EPT and may be applied in clinical management of EPT in association with other prognostic indicators in order to identify high-risk patients.

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