(38.9%), epidural abscess (38.9%), and bone/joint infections (33.3%). Antibiotic use disorders (OUD) were most common (94.4%), followed by cocaine (33.3%) and benzodiazepines (16.7%). All individuals completed the recommended course of IV antibiotics. All OUD patients received buprenorphine (52.9%) or methadone (47.1%). Two (11.1%) relapsed to drug use during OPAT, but no instances of line tampering, thrombosis, line infection or line dislodgement were identified. No deaths or overdoses were reported. Collectively, 504 inpatient days were compared. With 390 individuals without any history of IDU, those with IDU history were significantly younger (38.4 vs. 59.0, \( P < 0.0001 \)), had fewer episodes of endocarditis (38.9% vs. 43.6%) and bone/joint infections (33.3% vs. 41.8%), but more epidural abscesses (38.9% vs. 31.3%). There were no statistical differences in rates of readmission (22.2% vs. 11.3%), line complications (0% vs. 3.5%), mortality (0% vs. 1.0%), ID clinic visit attendance (100.0% vs. 82.0%), or number of days on OPAT (28.0 vs. 30.1).

Results add further evidence of OPAT’s safety among PWID and that integration of addiction treatment may be feasible. OPAT outcomes were similar without any history of IDU. More research is needed to study the impact of integrating addiction treatment with OPAT for PWID.

### Table 1: Summary of demographic and clinical variables of those with and without history of injection drug use.

| History of IDU | No History of IDU | \( P \) |
|---------------|-------------------|------|
| Age (yrs)     | \( 38.4(10.3) \) | \( 39.0(10.3) \) | 0.0010 |
| Gender        | M (51.0%)         | M (50.0%) | NS    |
| Site of infection | C (51.9%) | C (51.9%) | 0.0011 |
| Enterobacteriaceae | C (51.9%) | C (51.9%) | 0.0011 |
| Other          | C (51.9%) | C (51.9%) | 0.0011 |
| Site of infection | No history of IDU | N/A | N/A |
| Enterobacteriaceae | C (51.9%) | C (51.9%) | 0.0011 |
| Other          | C (51.9%) | C (51.9%) | 0.0011 |
| Op-AT outcomes | Continuous infusion (C-I) | Continuous infusion (C-I) | N/A |
| N/A | N/A | N/A |
| N/A | N/A | N/A |

### Disclosures

All authors: No reported disclosures.

### 769. Comparison of Vancomycin Continuous and Intermittent Infusion Dosing Strategies Among Patients in an Outpatient Antimicrobial Therapy Program

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**Session:** What’s New in Clinical Practice?
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**Background.** Vancomycin may be administered via intermittent infusion (I-I) or continuous infusion (C-I). C-I vancomycin has advantages including the potential for less nephrotoxicity; however, available data are inconsistent and vary based on inpatient and outpatient settings. Thus, the primary objective of this study was to compare rates of nephrotoxicity in patients who received C-I or I-I vancomycin in an outpatient parenteral antimicrobial therapy (OPAT) program. Secondary objectives included time to onset of nephrotoxicity and clinical failure.

**Methods.** This was a single-center, propensity score-matched, retrospective cohort study of patients who received C-I or I-I vancomycin for at least one week in the OPAT program between October 1, 2017 and March 31, 2019. Exclusion criteria included patients lost to follow-up, age less than 18 years old, and those requiring renal replacement therapy. Nephrotoxicity was defined as a serum creatinine (Scr)increase of >0.5 mg/dL or >50% from baseline for two consecutive measurements. Clinical failure was defined as unplanned readmission, extension of planned therapy, or change in antibiotic therapy.

**Results.** Three hundred patients were identified who received C-I or I-I vancomycin. After propensity score matching and exclusion criteria were applied, 74 patients were included in each cohort. Demographic information was similar between cohorts including baseline Scr, age, gender, comorbidities, concurrent nephrotoxins, indication, and vancomycin duration. C-I was associated with a 3.22 fold decrease in nephrotoxicity risk when compared with I-I [C-I: 6.8% vs. I-I 18.9%; OR (95% CI): 3.22 (1.10–9.46), \( P =0.027 \)]. C-I was associated with a significantly slower onset to nephrotoxicity compared with I-I (10/74, 13.7% vs. 17/74, 23.0%; OR (95% CI): 2.92 (1.08–7.88), \( P =0.036 \)). C-I was associated with a significantly lower onset to nephrotoxicity compared with I-I (P = 0.035; Figure 1). A significant difference in clinical failure was not observed between C-I and I-I (10/74, 13.7% vs. 17/74, 23.0%; \( P =0.147 \)).

**Conclusion.** C-I vancomycin was associated with a lower nephrotoxicity risk and slower onset to nephrotoxicity, but no difference in clinical failure rates when compared with I-I.

### Disclosures

All authors: No reported disclosures.