of Southern Nevada. Treatment was considered empiric when antibiotic was given prior to culture results. Escalation was the additional of an aminoglycoside or colistin after the start of C/T.

Results. There were 30 patients in the study. Average age was 57 (SD = 16) and most 19 (63%) were male, Caucasian 22 (73%) and were admitted from the community or home 18 (60%). The most frequent comorbidities were diabetes 13 (43%), heart disease 12 (40%) and chronic pulmonary disease 10 (33%). Previous medical history within 90 days included 15 (50%) hospitalizations, 13 (43%) infections, 6 (20%) Intensive Care Unit stays and 7 (23%) surgeries. All patients received a GN antimicrobial within 30 days prior to C/T. Ninety-three percent of infections were due to PSA and 17 (57%) were polymicrobial. All but 4 patients had multidrug-resistant PSA. The most frequent source of infection (some multiple sources) was respiratory 20 (67%), cUTI 8 (27%) and sepsis 5 (17%). Empiric C/T therapy was given to 7 (23%) patients. One patient required escalation of therapy after C/T. Average duration of C/T was 10 (SD = 5.4) days. 23 (77%) patients were discharged within 30 days of last dose of therapy. Microbiological eradication was documented for 12 patients. There were 5 (17%) readmissions, but none associated with a GN infection. Six patients died (1 bilateral stroke, 1 cancer, 2 septic shock, 1 pneumonia and 1 complications of burn).

Conclusion. In this study, C/T was used in patients with serious infections primarily due to PSA, with most patients discharged within 30 days and no patients readmitted due to GN infection. This study provides important insights on how C/T is used in clinical practice.

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