the two groups were similar. Inpatient mortality was found to be significantly higher in ENT patients than NO ENT patients (51.5% vs. 29.4%. P = 0.009). In the multivariable analysis, risk factors found to be independently associated with mortality included enterococcal bacteremia (OR 3.96, 95% CI 1.61–9.73), MELD score (OR 1.11, 95% CI 1.06–1.19), and APACHE II score (OR 1.14, 95% CI 1.06–1.23).

Conclusion. Enterococcal bacteremia, MELD score, and APACHE II score were found to be independent risk factors for all-cause inpatient mortality in patients with liver cirrhosis. Future studies are needed to elucidate how treatment choice and bacterial characteristics might also influence patient outcomes.

Disclosures. All authors: No reported disclosures.

124. Impact of Levofloxacin MIC on Outcomes with Levofloxacin Step-down Therapy in Enterobacteriaceae Bloodstream Infections
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Background. The Clinical and Laboratory Standards Institute reduced the levofloxacin minimum inhibitory concentration (MIC) breakpoint from ≤0.5 to ≤0.5 mg/L for Enterobacteriaceae in 2019 guidelines. The reduction is based on Monte Carlo simulations for a levofloxacin dose of 750 mg daily. The aim of this study was to determine whether there was a difference in clinical outcomes in the treatment of Enterobacteriaceae with levofloxacin step-down therapy, retrospectively comparing patients with isolates with low levofloxacin MICs (≤0.5 mg/L) to high MICs (1–2 mg/L).

Methods. This retrospective, two-center cohort study included patients 21 years of age with a monomicrobial Enterobacteriaceae bacteremia with a levofloxacin MIC ≤2 mg/L from March 2017 through December 2018. Patients had to have received treatment with 23 days of levofloxacin step-down therapy, initial intravenous therapy with an agent active against the isolated organism, and total duration not exceeding 16 days from first negative blood culture. A subset of patients whose isolates had low levofloxacin MICs were randomly selected for comparison to all patients with high levofloxacin MICs in a 3:1 ratio. The primary outcome was a composite endpoint of recurrence and mortality within 30 days of completion of the antibiotic course. Secondary outcomes included post-culture length of stay (LOS) and 30-day readmission rate.

Results. Thirty-three patients with high MIC and 99 with low MIC were included. Urinary source was predominant and occurred in 44% of patients, and Enterococcus coli was the infecting organism in 48%. Over 80% of patients experienced source resolution or control. The composite endpoint occurred in 8.1% of the low MIC group and 9.1% of the high MIC group (P = 0.856). Median LOS was 4.9 days (IQR 3.7–8.0) in the low MIC group and 4.3 days (IQR 3.2–6.8) in the high MIC group (P = 0.384), and readmission rate was 17.2% in the low MIC group and 15.2% in the high MIC group (P = 0.787).

Conclusion. There was no between-group difference in the primary outcome of recurrence and mortality, with a low overall event rate and short LOS post-culture. These results suggest that levofloxacin effectiveness may be sustained in patients with MICs of 1 or 2 despite levofloxacin not meeting susceptibility criteria by new definitions.

Disclosures. All authors: No reported disclosures.

125. The Clinical Impact of 16S rRNA Bacterial Sequencing in Infective Endocarditis
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Background. The term "Cascade of Care" has been used to analyze care delivered by a health system for conditions such as HIV, hepatitis C, tuberculosis, and diabetes. It outlines sequential steps required to reach a specific outcome (i.e., viral suppression in the case of HIV). This allows to estimate the proportion of patients achieving each step and to identify points in care. Medication-assisted treatment (MAT) is integral in the treatment of patients with infective endocarditis (IE) and opioid use disorder (OUD). We propose a Cascade of Care aiming to identify fundamental milestones in the management of these patients.

Methods. A retrospective cohort study examined patients with IE in the setting of OUD hospitalized between July 1, 2007 and January 1, 2015 to the Cleveland Clinic. We identified 4 key steps along the treatment cascade of these patients and estimated the proportion of patients: (1) evaluated by an addiction treatment service, (2) prescribed MAT while in-patient, (3) prescribed MAT at discharge, and (4) continued MAT at least 90 days after discharge.

Results. Of 273 patients with IE in the setting of OUD, 134 (49%) were evaluated by an addiction treatment service, 2 prescribed MAT while in-patient, 3 prescribed MAT at discharge, and 4 continued MAT at least 90 days after discharge.

Conclusion. Describing the process of addiction treatment for patients with IE and OUD in the format of a cascade of care provides a powerful quantitative method to identify gaps in care and can be used as a resource to implement interventions to address losses. We found only 8% of these patients continued MAT in the community after discharge. This study provides an estimate of how compromised the potential benefits from medical and surgical treatment for IE are by the lack of an effective approach to OUD after hospital discharge.

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127. Novel Treatment Approach for Left Ventricular Assist Device-related Infections
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