1712. Candida auris: A Case Series at a Large Tertiary Care Medical System  
Preethi Yeturu, MD1; Amanda Harrington, PhD2; Gail Reid, MD, MSCTS1; Loyola University Medical Center, Chicago, Illinois; 2Loyola University and Medical Center, Maywood, Illinois; 3Loyola University Chicago, Stritch School of Medicine, Maywood, Illinois  
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Background. Candida auris has become one of the most feared pathogens globally and has been associated with increased mortality. Invasive disease has been reported in patients with critically ill and/or other immunosuppressing conditions. The purpose of this study was to analyze the characteristics of these patients, and to assess the interrelation to prior epidemiological data.  
Results. This was a retrospective study of the patients with positive C. auris cultures and histopathology at a tertiary care transplant center, and Gottlieb Memorial Hospital, a community-based medical center. Both hospitals have reported cases of C. auris infection. We reviewed the microbiology laboratory data and clinical information of all positively identified cases over a 17-month period.  
During this 2-month period, CrAg LFA was positive in 12 patients. The diagnosis of cryptococcosis could not be confirmed by additional testing in 9 (75%) of patients. Matrix-assisted laser desorption ionization time-of-flight mass spectrometry (MALDI-TOF MS; Burker, Biotyper RUO) was used for identification in all of the cases and susceptibility testing was performed using microbroth dilution (Sensititre, YeastOne) for all isolates.  
Conclusions. False-positive tests are likely to be blamed for the continued use of antifungal therapy. The rate of false-positives is high enough to suggest that a more specific test is needed to reduce the overuse of antifungal therapy.  
Table 1: Characteristics and Treatment of Nine Patients with False Positive Results

| Characteristics | N (%) |
|-----------------|-------|
| Age             | 51.7 (25-82) years |
| Male            | 8 (88.9%) |
| Cirrhosis/Liver disease | 3 (33.3%) |
| Underwent Lumber Puncture | 5 (55.6%) |
| Antifungal Therapy | 8 (88.9%) |
| Antifungal Therapy for > 4 weeks | 3 (33.3%) |

1713. Impact of False-Positive Low-Titer Cryptococcal Antigen Testing  
Mahesh Bhatt, MD; Julie A. Ribes; MD, PhD; Yaneet Arora, MD, MPH; Thein Myint, MBBS; University of Kentucky, Lexington, Kentucky  
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Background. At University of Kentucky (UK) HealthCare, the transition from latex agglutination testing (Remel, Lenexa, KS) to IMMY Cryptococcal Antigen Lateral Flow Assay (CrAg LFA) occurred in September 2016. A few months later, it was noticed that several cryptococcal cases were diagnosed with weak positive test results where the diagnosis could not be confirmed by additional testing. The purpose of this study was to analyze the characteristics of these patients, and to assess the interventions they received based on positive results.  
Methods. This was a retrospective study of the patients with positive CrAg LFA treated at UK HealthCare from November to December 2016. Low antigen titers (< 1:20) were considered to be false positive if repeat testing with the Remel Cryptococcal Latex assay, IMMY latex and IMMY microwell EIA were negative, cultures and histopathology were negative and there was no clear clinical evidence of infection.  
Results. During this 2-month period, CrAg LFA was positive in 12 patients. The diagnosis of cryptococcosis could not be confirmed by additional testing in 9 (75%) individuals. Cirrhosis/liver disease was present in 3 (33.3%) patients, 5 (55.6%) underwent liver puncture and antifungal therapy was administered in 8 (88.9%) patients (Table 1). CrAg LFA was false positive in 1/2 (50%) HIV, 3/3 (100%) transplant, and 5/7 (71.4%) non-HIV/non-transplant patients (Figure 1). Among the false positives, 4 (44.4%) patients had titer of 1:5, two (22.2%) had 1:20, and the original positive screen was not detected upon retesting in 3 (33.3%) other patients. One HIV patient received a complete treatment course for unconfirmed cryptococcal meningitis because an LP could not be performed.  
Conclusions. False-positive low CrAg LFA titers led to unnecessary tests, antifungal treatments and prolonged hospitalization in some patients. One third of these individuals had cirrhosis/liver disease. Other institutions also reported false-positive low CrAg LFA titers. As a result, the company staged a recall of the specific lot and, despite increased awareness, its incidence is still low. Recently there has been growing concern regarding drug resistance, difficulty in identification, as well as problems with eradication.  
Methods. Loyola Medicine includes Loyola University Medical Center, a large tertiary care transplant center, and Gottlieb Memorial Hospital, a community-based medical center. Both hospitals have reported cases of C. auris infection. We reviewed the microbiology laboratory data and clinical information of all positively identified cases over a 17-month period.  
Results. C. auris was isolated from 14 patients in cultures from blood, urine, wounds, and respiratory secretions. Matrix-assisted laser desorption ionization time-of-flight mass spectrometry (MALDI-TOF MS; Burker, Biotyper RUO) was used for identification in all of the cases and susceptibility testing was performed using microbroth dilution (Sensititre, YeastOne) for all isolates.  
Discussion. False positive results are likely to be blamed for the continued use of antifungal therapy. The rate of false-positives is high enough to suggest that a more specific test is needed to reduce the overuse of antifungal therapy.

1714. Testing a Novel Clinical Surveillance Case Definition for Invasive Mold Infections  
Karyn Beer, MS, PhD1; Hilary Kelly; MPH2; Rebekah Blakney, MS3; Taylor Chambers, MPH4; Lewis Perry, DrPH, MPH3; Sabrina Singleton, MPH, DHSc5; Eduard Matkovic, MD1; Gillian Hale, MD1; Stepy Thomas, MSPH1; Nora Oliver, MD, MPH2; Alexandra Dretler, MD3; Sharon Tsay, MD2; Monica M. Farley, MD3; Brendan R. Jackson, MD, MPH3; CDC, Atlanta, Georgia; 5Georgia Emerging Infectious Diseases Program, Atlanta, Georgia; 6VA Health System/Georgia Emerging Infectious Diseases Program, Atlanta, Georgia; 7Georgia Emerging Infectious Diseases Program/Georgia VA Health System, Atlanta, Georgia; 8Emory University, Georgia Emerging Infectious Diseases Program, Atlanta, Georgia; 9Emory University, Atlanta, Georgia; 8Emory University, Georgia Emerging Infectious Disease Program, Atlanta, Georgia  
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Background. Invasive mold infections (IMI) such as aspergillosis and mucormycosis are often fatal among immunosuppressed patients and have caused high-profile outbreaks. Surveillance for IMI is challenging because distinguishing a case from colonization or contamination is complex. The established case definition, Mycoses Study Group (MSG) criteria, lacks sensitivity. Because the need for surveillance remains, we designed a pilot IMI surveillance system within the Georgia Emerging Infectious Disease Program. Here, we describe cases identified through this system, using both the MSG criteria and a novel, more sensitive case definition.  
Methods. To identify potential IMI cases, we captured fungal cultures positive for mold, histopathology specimens with evidence of fungal tissue invasion, and positive galactomannan results within a 60-day window at three large hospitals in Atlanta during March 2017-2018. We excluded dimorphic fungi and hair and nail specimens. Of 194 potential cases, we selected 24 for complete medical chart review. Two physicians classified cases as proven, probable, or non-case according to MSG criteria. Cases that partially met MSG probable criteria and included antifungal treatment were classified as clinical cases; definitions were mutually exclusive (Figure 1).  
Results. Of 24 potential IMI cases, 16 (66%) met an IMI case definition, including 10 (62%) proved and 9 clinical cases. Inter-rater agreement was 92%. Most (5/7) MSG cases involved Aspergillus and were more likely to have cancer, a transplant, or other immunosuppression compared with clinical cases (Figure 2 and 3). Clinical cases included conditions not specified in MSG criteria, including burns (1), wounds (1) or eye (4) infections. MSG and clinical cases more often had antifungal treatment (16/16 vs. 1/8) or died (4/16 vs. 0/8) compared with non-cases.  
Conclusions. In this preliminary analysis of potential IMI cases, most represented true invasive infections, indicating effective exclusion of most colonization. Most of the 16 cases were classified as clinical, however, and would have been missed in a system relying on the MSG criteria alone. Results suggest that a less-specific clinical case definition incorporating antifungal treatment may improve the sensitivity and utility of IMI surveillance.
Table 1: Site of Incident Specimen and Mold Species Identification

| Specimen             | N  | N  | N  |
|----------------------|----|----|----|
| Pulmonary            | 3  | 2  | 2  |
| Skin, Nails, or Scalp| 0  | 0  | 0  |
| Other Skin Lesion    | 1  | 1  | 2  |
| CNS                  | 0  | 4  | 0  |
| Others               | 3  | 5  | 5  |

Final Mold Identification

- Aspergillus: 5 cases of 22
- Mucorales: 1 case of 20
- Fusarium: 1 case of 20
- Others: 0 cases of 6

*Other molds: Cutispora, Penicillium, Macrophomina, Absidia, Mortierella, Trichosporon

** ambulance personnel were not notified about CRP group and were not documented.

** Glasgow Coma Scale was ≤15 (P = 0.01) than nonpregnant women.

** 0.01) than nonpregnant women.

** 0.01) than nonpregnant women.

** 0.01) than nonpregnant women.

** 0.01) than nonpregnant women.

** Baseline serum CRP could be a surrogate marker for undiagnosed co-infections or may reflect immune dysregulation leading to worse outcomes in persons with advanced AIDS and concomitant cryptococcal meningitis. Additional studies investigating more specific inflammatory biomarkers and the longitudinal trend in CRP with effective therapy would be informative.

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1715. Coccioidiomycosis Outcomes Among Hospitalized Pregnant and Postpartum Women—California, 2000–2016

Victoria Chu, MD, MPH; Gail L. Sondermeyer Cooksey, MPH; Adam Readhead, PhD; Duc Vugia, MD, MPH; Seema Jain, MD; California Department of Public Health, Richmond, California

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** Background.** Coccioidiomycosis (CM) in pregnancy has been associated with severe, disseminated disease. Publications are largely limited to case reports. Using California administrative hospital and birth registry data, we describe maternal and neonatal outcomes among pregnant and postpartum women hospitalized with CM.

** Methods.** We extracted California records from 2000 to 2016 for women ≥18 years of age. We identified women who were pregnant or post-partum (≤30 days of childbirth) during their hospitalization. We used chi-squared tests to compare pregnant/post-partum women and non-pregnant women hospitalized with CM to date and corroborates that pregnant/post-partum women are more likely to have disseminated CM than non-pregnant women. Their infants may be more likely to be born <34 weeks gestational age and have a low birth weight. This highlights the need for clinicians caring for pregnant/post-partum women who may live or travel to an area where CM occurs to be aware of the risks for these women and their infants.

** Results.** We identified 2,372 women with ≥1 CM hospitalization; 187 (8%) were pregnant/post-partum and there were 188 infants (one set of twins). Pregnant/post-partum women were more likely to be Hispanic (59% vs. 44%, P < 0.01), younger (median age 27 vs. 35 years, P = 0.01), without comorbidities (60% vs. 56%, P < 0.01), and have disseminated CM (32% vs. 21%, P < 0.01) than nonpregnant women. Hospitalized pregnant/post-partum women with CM were more likely to have CM dissemination compared with hospitalized non-pregnant women with CM (odds ratio 2.0, 95% confidence interval 1.4–2.8). Among infants of pregnant women hospitalized with CM, 18 (10%) were born < 34 weeks gestational age and 11 (8%) of 134 term (>37 weeks) infants had a birth weight <2,500 g; compared with 3% and 3% (median age 27 vs. 35 years, P < 0.01) than nonpregnant women.

** Conclusion.** Higher baseline serum CRP is associated with increased mortality in HIV-infected individuals with first-episode cryptococcal meningitis. The serum CRP could be a surrogate marker for undiagnosed co-infections or may reflect immune dysregulation leading to worse outcomes in persons with advanced AIDS and concomitant cryptococcal meningitis. Additional studies investigating more specific inflammatory biomarkers and the longitudinal trend in CRP with effective therapy would be informative.

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1716. Baseline Serum C-Reactive Protein Level Predicts Mortality in Cryptococcal Meningitis

Supavit Cheshchadai, MD; Nicole Engen, MS; Joshua Rhein, MD; Lillian Tugume, MBChB; Tadeo Kitaa; Kandole, bachelor of Biomedical laboratory technology; Maha Abassi, DO; Darlisha A. Williams, MPH; Caleb Skipper, MD; Kathy H. Hullisek, PhD; Abu Kisekka; Musibire, Masters of Medicine; David Meyra, PhD; David Boulware, MD, MPH; University of Minnesota, Minneapolis, Minnesota; School of Public Health, University of Minnesota, Minneapolis, Minnesota; 1Infectious Diseases Institute Makerere University, Kampala, Uganda; 2Cryptococcal Meningitis Trials, Kampala, Uganda; 3Infectious Diseases, Minneapolis, Minnesota; 4Mulago National Referral Hospital/infectious Diseases Institute, Kampala, Uganda; 5Infectious Diseases Institute, College of Health Sciences, Makerere University, Kampala, Uganda

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** Background.** C-reactive protein (CRP) is an acute-phase protein produced by the liver in response to systemic inflammation. CRP is a helpful surrogate biomarker widely used in various infections, particularly for following the progression and resolution of infection. We aimed to determine the association between baseline CRP level and cryptococcal meningitis outcome.

** Methods.** We reviewed 168 prospectively enrolled HIV-infected Ugandans with confirmed first-episode cryptococcal meningitis. Baseline serum samples collected within 5 days from diagnosis had CRP levels measured and categorized into quartiles. We compared baseline serum CRP with 18-week survival using unadjusted time-to-event analysis.

** Results.** Of 168 participants, the first quartile of baseline serum CRP was 83.6 mg/L. Baseline CD4 count, HIV viral load, and cerebrospinal fluid results did not differ by quartile. Participants with CRP >49.5 mg/L more likely presented with Glasgow Coma Scale <15 (P = 0.03). The 18-week mortality rate was 54.8% (46/84) in the highest two quartile CRP groups (49.5 mg/L), 40.5% (17/42) in the mid-range CRP group (29–49.5 mg/L), and 14.3% (6/42) in the low CRP group (<29 mg/L) (P < 0.001) (Figure 1).

** Conclusion.** Higher baseline serum CRP is associated with increased mortality in HIV-infected individuals with first-episode cryptococcal meningitis. The serum CRP could be a surrogate marker for undiagnosed co-infections or may reflect immune dysregulation leading to worse outcomes in persons with advanced AIDS and concomitant cryptococcal meningitis. Additional studies investigating more specific inflammatory biomarkers and the longitudinal trend in CRP with effective therapy would be informative.

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1717. Cryptococcal Meningitis: A Comparison of Clinical Features and Outcomes by HIV Status

Amy Pate, MD MPH; Carlos Franco-Paredes, MD MPH; Andres Henao-Martinez, MD; University of Colorado, Aurora, Colorado

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** Background.** Cryptococcal meningitis is an opportunistic fungal infection associated with HIV and other forms of immunosuppression. We lack a clear understanding of cryptococcal meningitis (CM) among HIV-negative patients in the United States. Our aim was to compare clinical features and outcomes across HIV status in patients with laboratory-confirmed cryptococcal meningitis.

** Methods.** We conducted a retrospective cohort study of patients with laboratory-confirmed HIV-infected culture or antigen test) cryptococcal disease treated at a tertiary care center from January 2000 to September 2018. Patients were identified via local laboratory and TrinetX datasets. Data were gathered on demographics, HIV status, site of infection, clinical presentation, cerebrospinal fluid (CSF) profiles, hospital course, and mortality. Organ transplant recipients and/or non-neonatal infections were excluded.

** Results.** Seventy patients with cryptococcal disease were identified. Our final sample included 36 CM patients with a mean age of 48.8 ± 13.2 years; 66.7% (n = 24) had HIV. Median (IQR) absolute CD4 count for the HIV group was 35(24) (10–80/