of the T2 and BC in Tx and non-Tx patients were compared. BC obtained within 7 days before or after the T2 test were included in the analysis. TAT, sensitivity, specific- ity, PPV and NPV were calculated using positive BC as the standard. Differences between groups were assessed using two sample proportions testing at α = 0.05.

Results. A total of 1,272 patients with suspected candidemia had T2 done: 1,162 (91%) non-Tx and 110 (9%) Tx patients. Average TAT for T2 was 13 hours (5–41) vs. 34 hours (21–109) to initial positive BC result and 4 days (3–13) to species-specific BC result. In four non-Tx patients with negative T2, C. butani and C. dubliniensis and C. kefyr were isolated in BC. Performance characteristics of T2 and BC in the two groups is shown (Table 1). Of the 12+2BC- cases (n = 104), 9% had retinitis and 9% had invasive candidiasis.

Conclusion. The rapid TAT, good sensitivity, and high NPV of T2 in Tx patients has clinical implications and can help support antifungal stewardship efforts in this population. The clinical significance of T2 positivity in the presence of negative BC needs further investigation.

Table 1: Performance Characteristics of T2 Compared with BC (n = 1,272)

| T2 | Non-Tx (n = 1,162) | T2 + and blood culture + | 5 (4.5%) | 35 (3.01%) | 0.3917 |
|----|------------------|--------------------------|----------|------------|--------|
| T2 | and blood culture –  | 19 (17.3%) | 86 (7.4%) | 0.0003 |
| Sensitivity | 83.3% | 46.1% |
| Specificity | 91.9% | 92.4% |
| PPV | 20.8% | 28.9% |
| NPV | 98.8% | 96.2% |

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1134. Strongyloides Stercolaris Serology in Transplant Patients: To Test or Not? Karla Rivera Rivera, MD; Tulsi Shah, MBBS; Julia Garcia-Diaz, MD, FIDSA; and Jonathan Hand, MD,

Methods. Patients were identified using EPIC-CLARITY with ICD-9 and ICD-10 codes for any solid-organ transplant from OMC from July 2012 to December 2016. Inclusion criteria were age 18 or older, patients evaluated for solid-organ transplant, and Strongyloides IgG testing. Patients were excluded if they had other immunocompromising conditions or exposures including but not limited to steroids, TNF-alpha, and biologic agent use. The primary outcome was the overall prevalence of Strongyloides seropositivity within transplant candidates at Ochsner Medical Center (OMC).

Results. Of those, 985 were unique patients (62 patients had multiple serological tests). Of those, 985 were unique patients (62 patients had multiple serological tests). Of those, 985 were unique patients (62 patients had multiple serological tests). Of those, 985 were unique patients (62 patients had multiple serological tests). Of those, 985 were unique patients (62 patients had multiple serological tests). Of those, 985 were unique patients (62 patients had multiple serological tests).

Conclusion. Strongyloides stercoralis is an intestinal nematode endemic to the tropics, subtropics, and to a limited extent the United States and Europe. The global estimate of the strongyloides are reported to range from 3 to 30 million infected worldwide; however, the true US prevalence is unclear. The seroprevalence of infection in solid-organ transplant candidates and recipients in the New Orleans, Louisiana region is also unknown. The purpose of this study was to identify the prevalence of Strongyloides seropositivity within transplant candidates at Ochsner Medical Center (OMC).

1136. Universal Prophylaxis for Prevention of Invasive Aspergillosis in Lung Transplant Recipients Alexis Guernetié, DO; Adrian Gonzalez, MD and Amir Emizazou, MD, University of Florida, Gainesville, Florida.

Results. We analyzed a total of 1,047 patients who had 1,128 tests ordered for Strongyloides. Of those, 985 were unique patients (62 patients had multiple serological tests resulting in 818 repeat tests). During July 1, 2012 to July 31, 2016, testing yielded a total of 822 tests. From August 1, 2016 to December 31, 2016 testing yielded 306 tests.

Conclusion. Our data suggest that testing based on risk stratification yielded a lower prevalence rate as compared with generalized testing, underestimating the true incidence of disease (2.7% vs. 6.9%). Testing all patients being evaluated for transplantation will capture a greater number of patients with positive serology.

Disclosures. J. Garcia-Diaz, Astellas Pharma: Speaker’s Bureau, Speaker honorarium.

1138. Retrospective Cohort Analysis of Amphotericin B Nephrotoxicity in Kidney Transplant Recipients Mariam Assi, MD; Dominic Engracia, BS; Idris Takuwu, PharmD; Gazara Gupta, MD; Narayana Kurbanova, RN; BSN, BA; and Oveimar De La Cruz, MD, Internal Medicine, Virginia Commonwealth University Health System, Richmond, Virginia; School of Medicine, Virginia Commonwealth University, Richmond, Virginia; Commonwealth University Health System, Richmond, Virginia; Nephrology, Virginia Commonwealth University Health System, Richmond, Virginia; Infectious Diseases, Virginia Commonwealth University Health System, Richmond, Virginia.

Results. There was a total of 225 observations from the 45 patients. Two patients (4.4%) had positive results with a mean of 4.153 (SE, 0.629) and 79 patients (17.3%) had positive results with a mean of 2.169 (SE, 0.409). There was no correlation of cold ischemic time (P = 0.86), primary graft dysfunction (P = 0.38), presence of Candida species (P = 0.048) or non-tuberculous mycobacteria (NTM) in bronchoalveolar lavage (P = 0.044), and viral pneumonitis (P = 0.047) with a positive BAL GM. All nine patients with GM >1 were switched to voriconazole from itraconazole which resulted in negative GM levels on follow-up bronchoscopy.

Results. Our data suggest that the implementation of universal antifungal prophylaxis with itraconazole may not be efficacious in preventing IA in lung transplant recipients. On the other hand, surveillance with BAL GM is a strategy that can lead to early detection of IA in patients during the first year after lung transplantation.

Disclosures. All authors: No reported disclosures.

1137. Implementation of Universal Screening for Strongyloides Among Solid-Organ and Hematopoietic Stem Cell Transplantation Candidates in a Non-endemic Area Angelica Kotikoff, MD and Sapna Mehta, MD, Department of Medicine, NYU School of Medicine, New York, New York; NYU Transplant Institute, New York, New York.

Results. Strongyloides can lead to hyperinfection and disseminated infection after transplantation with significant morbidity and mortality. Treatment for Strongyloides prior to transplantation can reduce the risk of disseminated infection. Targeted screening based on travel history and country of origin incompletely identifies at-risk patients. Data on universal screening prior to solid-organ (SOT) or hematopoietic stem cell transplantation (HSCT) are limited. We implemented universal serology-based screening for strongyloides at our transplant center, located in a metropolitan non-endemic area.

Methods. We identified patients screened with serum Strongyloides IgG by ELISA during pre-transplant evaluation for SOT or HSCT from August 1, 2017 to April 25, 2018. We reviewed adherence to the screening recommendation by program type and the medical record of seropositive patients for country of origin, history of eosinophilia (>500 cell/μL), Gram-negative bacteremia, ova and parasite (O&P) examination and treatment.

Results. A total of 812 patients were evaluated for transplant during the study period: 484 for kidney, 152 for liver, 12 for liver/kidney transplant, 40 for heart, 24 for lung, and 100 for HSCT. 201 (24.7%) of the 812 patients were screened for Strongyloides; 107 (17%) evaluated for abdominal transplant, 32 (50%) for thoracic transplant, and 62 (60%) for HSCT. Seventeen (8.4%) of 201 patients screened tested positive: nine evaluated for kidney transplant, four for heart, one for liver, and three for HSCT. Nine of 17 patients (53%) were treated with Ivermectin or referred to Infec- tious Diseases clinic prior to our review. Ten (59%) seropositive patients were from the United States and travel to endemic areas: six patients were from countries other than the United States; and one from Puerto Rico. Two patients with Strongyloides had eosinophilia, one had history of Klebsiella pneumoniae bacteremia and one had stool O&P examination. Screening was higher when using an electronic order set (57% vs. 12%).

Conclusion. Universal screening for Strongyloides identified individuals with latent infection who did not have epidemiological or clinical findings suggestive of Strongyloides. Screening for Strongyloides was higher in transplant programs that incorporated the recommendation into an electronic order set.

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the median age in our cohort was 57. 40% were female, 60% were male. 60% had received a kidney transplant from deceased donors; 13.3% from a living related donor; 13.3% from a living unrelated donor; and 13.3% had received a combined kidney–pancreas transplant. 63.3% of patients had received liposomal amphotericin B; 33.3% had received lipid–complex amphotericin B; 3.3% had received conventional amphotericin B. We found an association between cumulative amphotericin B doses above 5,000 mg and AKI, whereby 64.7% of patients exposed to less than 5,000 mg of amphotericin B developed AKI and 100% of patients exposed to more than 5,000 mg of amphotericin B developed AKI (P = 0.017). We did not find an association between cumulative amphotericin B doses above 5,000 mg and AKI, whereby 64.7% of patients exposed to less than 5,000 mg of amphotericin B developed AKI and 100% of patients exposed to more than 5,000 mg of amphotericin B developed AKI (P = 0.436 and 0.288, respectively). We also did not find an association between such doses of amphotericin B and AKI mortality at 30 and 90 days (P = 0.869 and 0.193, respectively).

Conclusions: In the first descriptive analysis of a retrospective cohort of kidney transplant patients exposed to amphotericin B, our results suggest that the risk of nephrotoxicity may be significantly increased when a cumulative dose of 5,000 milligrams is exceeded. Our results also suggest that amphotericin B doses associated with nephrotoxicity in kidney transplant patients may not have an effect on allograft survival and patient mortality.

Disclosures. All authors: No reported disclosures.