associated with EIEC virulence. The EIEC O96:H19 stain 52.1 is an emergent diarrheagenic pathogen likely derived from an E. coli O96:H19 strain that acquired a Shigella-like virulence plasmid by horizontal transfer.

Disclosures. **All authors:** No reported disclosures.

1128. Utility of Anaerobic and Fungal Blood Cultures in the Pediatric Oncologic Population

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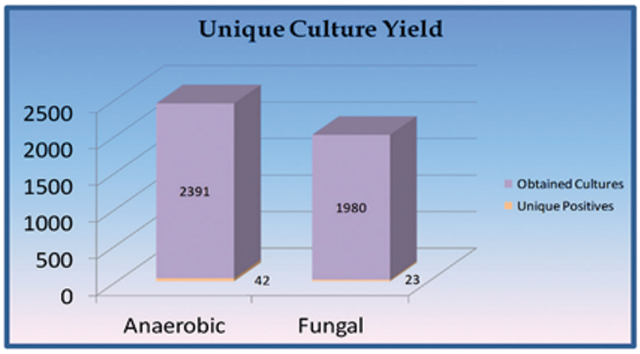
Background. In our institution, a febrile or ill appearing oncology patient will often be evaluated with aerobic, anaerobic, and fungal cultures. This is especially true in patients with persistent fevers without a clear etiology on empiric antimicrobial therapy. It is common for all three cultures to be repeated multiple times per admission.

Although this practice may seem sensible, there is to our knowledge little evidence to confirm its necessity in this population.

Methods. A record of all positive blood cultures originating from our institutions oncology ward was obtained from January 2010 to April 2017. Duplicate cultures (obtained on consecutive days with repeat organisms) were excluded. Each anaerobic and fungal culture was then evaluated for corollary positive aerobic cultures from the same time frame.

Results. A total of 10,950 blood cultures were evaluated for this study, including 2,391 anaerobic cultures and 1,980 fungal cultures. Forty-two unique anaerobic cultures (1.7%) were identified. The viridans group of *Streptococcus* was a large contributor with nine unique cultures. Only seven cultures of obligate anaerobes were observed: four cultures of *Clostridial* species, two *Propionobacterium acnes*, and one *Peptostreptococcus* species. Twenty-three unique fungal cultures (1.2%) were identified. Notably most of these isolates (14) were identified as having one colony present and regarded as probable contaminants. *Penicillium*, *Cladosporium*, and unidentified dermatiaceous molds were present in greatest frequency.

Conclusion. Over a 7-year period of routinely obtaining anaerobic and fungal cultures for febrile oncology patients only 42 unique anaerobic and 23 unique fungal cultures were identified. Given the predominance of facultative anaerobes, this may simply reflect the findings of increased blood sampling rather than added utility of the growth medium. Similarly, even among the limited unique fungal cultures the majority were of suspect validity given the presence of a single colony. These findings suggest judicious use of selective growth media in cases with higher clinical suspicion may be more useful than empiric evaluation.



Species Identified (Anaerobic Cultures)	Number of Isolates (Total = 42)
Streptococcus (viridans group)	9
Enterobacter cloacae	4
Enterococcus faecalis/faecium	4/1
Closdridual sp	4
Escherichia coli	4
Staphylococcus (coagulase negative)	3
Citrobacter freundii	2
Granulicatella sp	2
Pseudomonas aeruginosa	2
Propionobacterium acnes	2
Peptostreptococcus prevotii	1
Capnocytophaga sp	1
Salmonella (serogroup B)	1
Klebsiella pneumoniae	1
Streptococcus pneumoniae	1

Species Identified (Fungal Cultures)	Number of Isolates (Total = 23)
Penicillium	6
Cladosporium	5
Unidentified dematiaceous mold	4
Aspergillus sp	1
Bipolaris sp	1
Candida albicans	1
Candida parapsilosis	1
Rhodotorula mucilaginosa	1

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1129. Targeted Voriconazole Prophylaxis in Heart Transplantation Recipients

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Background. The use of antifungal prophylaxis, targeted or universal, remains controversial and unstudied. The goal of this study is to determine the role of targeted voriconazole prophylaxis (VORI) in prevention of invasive fungal infections (IFI) after heart transplantation (HT).

Methods. We conducted a single-center, prospective, observational cohort study of 276 HT recipients from June 2005 to April 2017 to characterize the incidence and outcome of IFI following targeted VORI. Starting in June 2013, HT recipients with thymoglobulin (ATG) treatment received VORI for 3 months. Probable/proven IFI were defined by EORTC/MSG criteria. Descriptive frequencies and univariate analyses were performed.

Results. Mean duration of follow-up post-HT was 1,165 days (0–3,152 days). 149 (54%) and 70 (25%) received basiliximab and thymoglobulin induction, respectively. Thirty-one (11%) received VORI, following use of ATG in the setting of induction (68%) or rejection (32%). VORI was started at median of 6 days (0–1,008 days) post-HT for a mean duration of 97 days (5–251 days). Overall, 23 IFIs occurred in 23 recipients (8%) at mean 283 days post-HT (range 2–1,579 days), including seven *Aspergillus* (one occurring after VORI completion), seven invasive *Candida* (five with candidemia), two *Rhizopus*, one *Cunninghamella*, two histoplasma, two blastomyces, one *Cryptococcus*, and one multifocal cutaneous Alternaria.

Characteristics and Outcomes of 276 Heart Transplant Recipients with Targeted VORI

	VORI (n = 31)	No VORI (n = 245)	P-value
Outcomes	%	%	
Invasive Aspergillosis	3.2	2.4	0.57
Invasive Candidiasis	0.0	2.9	1.00
IFIs	3.2	9.0	0.49
IFIs within 180 d	0.0	5.7	0.38
1-yr Mortality	22.6	19.6	0.70
Overall Mortality	12.9	9.0	0.51
Characteristics	% or Mean	% or Mean	
Mean Age in Years	48.7	57.7	0.001
Female Gender	54.8	29.4	0.004
African-American	45.2	19.6	0.001
ATG Induction	67.7	20.0	0.00
Desensitization	29.0	8.6	0.002
Antibody-mediated Rejection	45.2	18.0	0.00
2R/3R Rejection	30.8	36.0	0.96
Re-transplantation	12.9	2.9	0.03
Diabetes Mellitus	19.4	29.8	0.23
Renal Impairment	54.8	38.8	0.09

Conclusion. Targeted VORI resulted in reduced incidences of both early and overall IFI after HT although this did not reach statistical significance. Since instituting this strategy, we have observed a single case of aspergillosis following VORI discontinuation. Overall and 1-year mortality were not impacted. The use of antifungal prophylaxis following HT requires continued investigation both to determine efficacy and toxicity in this patient population.

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1130. Low Risk of *Pneumocystis jiroveci* Pneumonia in Patients With Waldenstrom's Macroglobulinemia on Ibrutinib

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