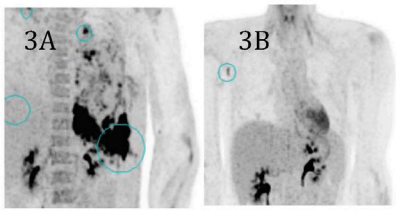
Fig. 3



3A. Pretransplant PET-CT demonstrating involvement of L lower lobe and contiguous structures. 1B. Posttransplant PET-CT with resolution at previously involved sites.

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1690. Risk Factors of Invasive Aspergillosis in Systemic Lupus Erythematosus Patients

Sithichai Kunawathanakul, MD[1]; Atibordee Meesing, MD[2]; Chingching Foocharoen, MD[1]; [1]Khonkaen University, Khonkaen, Khon Kaen, Thailand; [2]Khon Kean University, Rochester, Khon Kaen, Thailand

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Background. Invasive aspergillosis (IA) has been reported in systemic lupus erythematosus (SLE) patients. We assessed the risk factors of invasive aspergillosis in SLE patients.

Methods. A retrospective age- and sex-matched case–control study with ratio 3:1 in adult SLE patients from January 2002- December 2017 at Srinagarind Hospital, Khon Kaen University, KhonKaen, Thailand has been conducted. We excluded the patients who were overlap with other immunocompromised condition.

Results. Of 1,585 SLE patients, 22 patients (1.4%) had invasive aspergillosis and 66 controls were included in the study. The mean age was 36.9 ± 11.8 years and 76 (86.4%) patients were female. SLE patients who developed IA had statistically significant lower median total absolute lymphocyte count than control (503 vs. 1342 cells/mm^3, $P = 0.05$) and history of steroid treatment (adjusted OR 21.43, $P = 0.006$) were the risk factor of IA.

Conclusion. There was a low prevalence of IA in SLE patients. Low total lymphocyte count, renal impairment and history of steroid treatment were significantly associated with invasive aspergillosis in SLE patients.

Table1. Baseline Characteristics

	IA (n=22)	Non-IA (n=66)	Total (n=88)
Female (%)	19 (86.4)	57 (86.4)	76 (86.4)
Mean age (SD) (years)	36.9 (11.8)	36.9 (11.7)	36.9 (11.7)
Median ALC (IQR) (cells/mm^3)	503 (310-726)	1342 (693-2260)	948 (545-2032)
Median creatinine (IQR) (mg/dL)	1.4 (1.1-2.2)	0.7 (0.6-1.1)	0.8 (0.6-1.3)
Median ESR (IQR) (mm/h)	90 (75-119)	56 (30-79)	75 (44-90)
Median SLEDAI (IQR)	21 (13-25)	6 (4-10)	8 (4-14)
SLE manifestation (%)			
• Cutaneous involvement	4 (18.2)	21 (31.8)	25 (28.4)
• Arthritis	8 (36.4)	22 (33.3)	30 (34.1)
• Serositis	15 (71.4)	9 (13.6)	24 (27.6)
• CNS involvement	8 (36.4)	10 (15.2)	18 (20.5)
• Renal involvement	16 (72.7)	27 (41.5)	43 (49.4)
• AIHA	15 (68.2)	33 (50)	48 (54.5)
• Thrombocytopenia	7 (31.8)	9 (13.6)	16 (18.2)
Co-infections (%)			
• Bacteria	7 (31.8)	1 (1.5)	8 (9.1)
• Mycobacterium tuberculosis	7 (31.8)	0 (0)	7 (8)
• Strongyloidiasis	3 (13.6)	0 (0)	3 (3.4)
• CMV infection	1 (4.5)	1 (1.5)	2 (2.3)

AIHA; autoimmune hemolytic anemia, ALC; absolute lymphocyte count, CMV; cytomegalovirus, CNS; central nervous system ESR; erythrocyte sedimentation rate, IA; invasive aspergilosis, IQR; inter quartile range, SD; standard deviation, SLE; systemic erythematosus, SLEDAI; Systemic Lupus Erythematosus Disease Activity Index

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1691. *Cryptococcus* Species Other than *C. neoformans* and *C. gattii*: Are They Clinically Significant?

Edison J. Cano Cevallos, MD; Zachary A. Yetmar, MD; Raymund R. Razonable, MD; Mayo Clinic, Rochester, Minnesota

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Background. *Cryptococcus* sp. is a major cause of opportunistic infections in immunocompromised patients, with nearly all cases due to *C. neoformans* or *C. gattii*. There are occasional reports of other *Cryptococcus* species causing invasive human disease. However, their epidemiology and clinical significance are not fully defined. We sought to describe the patients with cultures positive for *Cryptococcus* species other than *neoformans* and *gattii*.

Methods. A retrospective descriptive review of patients with cultures growing *Cryptococcus* species other than *neoformans* and *gattii* from November 2011 to February 2019. Clinical and laboratory data were analyzed.

Results. Out of 177 cases with a culture positive for *Cryptococcus* sp., 54 patients (mean age, 53.3 years; 61% men) had a culture for *Cryptococcus* other than *neoformans* and *gattii*. The most common species were unspecified non-*neoformans*/*gattii* (10), *magnus* (9), *laurentii* (8), and *ater* (7). Three patients had active malignancies and 15 were on immunosuppressive drugs, 6 due to transplant. The most common sites or specimens were skin (16), respiratory (16), urine (7), joint (3), intravascular catheter (2), cerebrospinal fluid (2), oral (2), peritoneal fluid, donor liver transplant, bone marrow, sinus, nail, and cornea. Whereas 21 (38.9%) cultures were obtained due to local symptoms, there was only one case of invasive disease, affecting the peritoneum, while the majority was either unaddressed (25) or considered contaminants (17). Only 12 patients received antifungal treatment, where sources were skin (4), oral (2), peritoneum, donor liver, respiratory, vascular catheter, urine, and nail. Antifungal drugs were fluconazole, itraconazole, clotrimazole, caspofungin, and griseofulvin, for a mean duration of 37.6 days. Among patients who were not treated, four died within 6 months but mostly of unrelated causes (3) or not known (1).

Conclusion. This large series of patients with *Cryptococcus* sp. other than *neoformans* and *gattii* suggests that these species rarely cause clinically significant infection in humans. Only one case of invasive disease was found.

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1692. Epidemiology, Clinical Characteristics, and Outcomes of Candidemia in a Tertiary Hospital in the Dominican Republic

Rita Rojas Fermin, MD[1]; Edwin Germosen[2]; Alfredo J. Mena Lora, MD[3]; Anel E. Guzman, MSc[1]; Gilda Tolari, MSC[1]; Susan C. Bleasdale, MD[3]; [1]Hospital General Plaza de la Salud, Santo Domingo, Distrito Nacional, Dominican Republic; [2]Universidad Tecnologica de Santiago, Santo Domingo, Distrito Nacional, Dominican Republic; [3]University of Illinois at Chicago, Chicago, Illinois

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Background. Candidemia is a major cause of morbidity and mortality in hospitalized patients. The global epidemiology of invasive Candidiasis is changing, with distribution of species and resistance varying in different geographic and healthcare settings. There is a paucity of data on candidemia in the Dominican Republic (DR). Understanding epidemiologic risk factors and resistance rates may improve early diagnosis and empiric antifungal selection.

Methods. We performed a retrospective review of patients with positive Candida blood cultures from January 2017 to December 2018. Data were extracted from medical records. Clinical and demographic information, including co-morbidities, antifungal sensitivities, and outcomes were collected.

Results. A total of 52 cases were identified, 34 in 2017 and 18 in 2018. Ages ranged from <1 to 89 years and was distributed in various groups (Figure 1). The most common comorbidities included DM (38%), nephropathy (37%), cerebrovascular accident (25%), and malignancy (19%). Device use and prior antimicrobial exposure were the most common risk factors (Table 1). There was no antifungal resistance to amphotericin, voriconazole, or echinocandins. No fluconazole resistance was found in 2017, compared with 11% resistance in 2018 in *C. albicans*, *C. glabrata,* and *C. tropicalis* species. Mortality was 64% in 2017 and 61% in 2018.

Conclusion. Candidemia with non-albicans *Candida* species was common (87%). Susceptibilities and species varied by year but did not affect mortality. Resistance to fluconazole is rising but remains low and other antifungals retain susceptibility. Indwelling catheters, mechanical ventilation and antibiotic exposure were common risk factors in our cohort. Mortality for candidemia was high. Rapid diagnostic testing and early empiric therapy with echinocandins for patients at risk may curb mortality.

Figure 1. Age distribution of Candidemia