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Background. We present a rare case of *Scopulariopsis brumptii* endophthalmitis and discuss therapeutic strategies including systemic and intraocular anti-fungal therapy, and surgical intervention. The combination of highly resistant pathogen, unique sanctuary site, and vulnerable host makes this a challenging case.

Methods. We reviewed medical records of a patient who received HSCT for acute myelogenous leukemia and presented with acute right-sided eye pain and photophobia seven months posttransplant while on posaconazole prophylaxis.

Results. Ophthalmological examination showed pan-uveitis and vitritis. Skin examination was normal. Labs revealed leukopenia of 0.5×10^9/mL and (1,3)-β-D-glucan of >500 pg/mL. CT of chest and sinuses was unremarkable. Patient received intravitreal amphotericin B followed by voriconazole thrice weekly and oral posaconazole. Vitreous aspirate was negative for bacterial, mycobacterial, and fungal cultures and broad-range PCR. Subsequently patient developed new pre-retinal lesions and posaconazole was switched to intravenous liposomal amphotericin B. Intravitreal amphotericin B deoxycholate was continued. Vitrectomy was performed with cultures yielding *S. brumptii.* Susceptibility data demonstrated high minimal inhibitory concentrations (MICs) for posaconazole and voriconazole and low MICs for isavuconazole, amphotericin, and echinocandins. He was treated with 2 weeks of local and systemic amphotericin B therapy before developing acute kidney injury. He was then transitioned to isavuconazole. Intraocular injections were discontinued after 6 weeks when (1,3)-β-D-glucan was 46 pg/mL and resolution of retinal lesions. Patient was kept on isavuconazole chronic suppression.

Conclusion. *S. brumptii* is known for resistance to many antifungal agents. Our case highlights the importance of vitrectomy and intraocular drug injection due to poor penetration from systemic therapy. With aggressive local and systemic therapy and surgery, our patient had good outcome.

Figure 1. Funduscopic examination revealing retinal lesions.

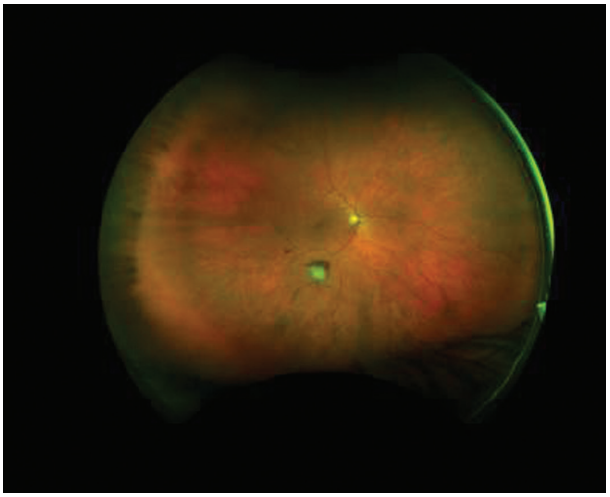
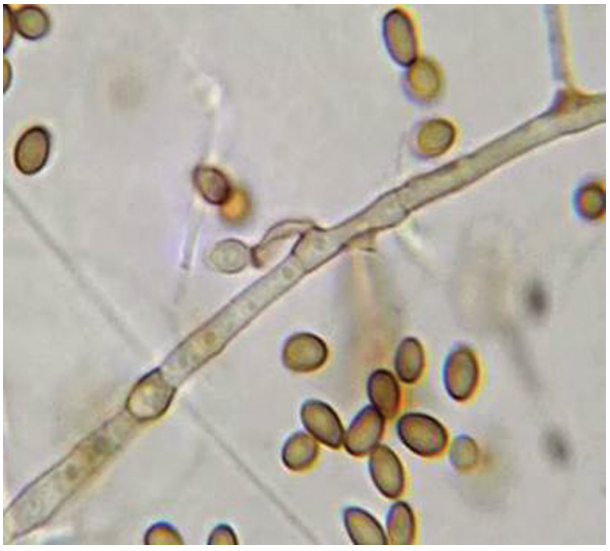


Figure 2. *Scopulariopsis brumptii* microscopic appearance.



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

333. Meningitis in Well-Appearing Febrile Infants Aged 1–90 Days
Anne J. Blaschke, MD, PhD, FIDSA, FPIDS[1]; E. Kent Korgenski, MT, MS[2] and Carrie L. Byington, MD, FIDSA[1,3,4]; [1]Department of Pediatrics, Division of Pediatric Infectious Diseases, University of Utah School of Medicine, Salt Lake City, Utah, [2]Department of Pediatrics, Pediatric Clinical Program, University of Utah School of Medicine and Intermountain Healthcare, Salt Lake City, Utah, [3]University of Utah Health Sciences Center, Salt Lake City, Utah, [4]Health Sciences Center, Texas A & M University, Bryan, Texas

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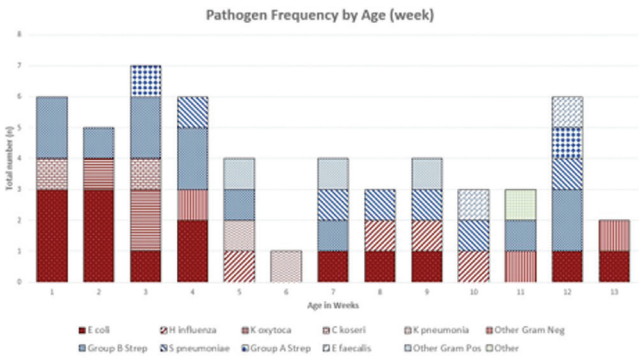
Background. Fever in infants 1–90 days of age is common. Bacterial meningitis (BM) is a rare, potentially fatal infection that may occur in well-appearing febrile infants (FI). Our objectives were to identify infants with BM in a large population of well-appearing FI and evaluate factors associated with the diagnosis of BM in this population.

Methods. The Intermountain Healthcare System (IHS) is comprised of 22 hospitals across Utah and Idaho and includes Primary Children's Hospital, the only pediatric hospital in a catchment of 400,000 miles[2]. IHS has a care process model for the well-appearing FI. We queried the IHS EHR from July 1, 2004 to September 30, 2016 and captured data on age, laboratory testing, and outcomes. Diagnosis of BM required positive CSF culture.

Results. We identified 21,135 FI episodes; 54 infants (0.26%) had a diagnosis of BM. Gram-negative organisms predominated in FI 1–28 days [15/24 (63%)] and caused 28/54 (52%) cases overall (Figure 1). FI 1–28 days were significantly more likely to have BM than those 29–90 days (0.41% vs. 0.20%; RR 2.11, 95% CI 1.24–3.61). Laboratory screening showed abnormal white blood cell count in 63% of FI 1–28 days with BM and 50% of FI 29–90 days ($P = 0.42$); bands were abnormal in 33% and 47% respectively ($P = 0.41$); urinalysis was abnormal in 21% and 11% ($P = 0.42$). CSF profile was performed and interpretable in 48/54 (89%); CSF pleocytosis was present in 30/48 [(63%; 15/21 (71%) 1–28 days and 15/27 (56%) $P = 0.34$]. Nine of 54 (17%) FI with BM would not have been considered "high-risk" based on laboratory criteria alone. Of FI with BM, only 31/54 (57%) had bacteremia with the same organism [17/24 (71%) in those 1–28 days; and 14/30 (47%) in those 29–90 days; $P = 0.099$].

Conclusion. BM is rare and challenging to predict in well-appearing FI. Abnormal screening laboratory values identified 83% of FI with BM. Awaiting blood culture results before performing lumbar puncture would potentially miss 40%. Age was the only predictor for BM risk in our cohort.

Figure 1.



Study Population			FI with BM Laboratory Evaluation: Abnormal/Total Performed (%)						
Age (d)	FI Episodes	BM n (%)	WBC	Bands	UA	Laboratory high risk	CSF Profile Performed	CSF Profile Interpretable	CSF Profile Pleocytosis	Bacteremia
1-90	21,135	54 (0.26)	30/54 (56)	22/54 (41)	7/47 (15)	45/54 (83)	51/54 (94)	48/51 (94)	30/48 (63)	31/54 (57)
1-28	5,808	24 (0.41)	15/24 (63)	8/24 (33)	4/19 (21)	20/24 (83)	24/24 (100)	21/24 (88)	15/21 (71)	17/24 (71)
29-90	15,327	30 (0.20)	15/30 (50)	14/30 (47)	3/28 (11)	25/30 (83)	27/30 (90)	27/27 (100)	15/27 (56)	14/30 (47)

Disclosures. **A. J. Blaschke**, BIoFire Diagnostics, LLC: I have intellectual property licensed to BioFire through the University of Utah, Independent Contractor and Investigator, Consulting fee and Licensing agreement or royalty. **C. L. Byington**, BIoFire Diagnostics, LLC: I have intellectual property licensed to BioFire through the University of Utah, Licensing agreement or royalty.

334. Implementation of FilmArray Meningitis/Encephalitis Panel at a Tertiary Medical Center
Sisham Ingnam, MD[1]; Philip Goldstein, MD[1]; Lynn Wardlow, PharmD, MBA, BCPS-AQ ID[2]; Joan-Miquel Balada-Llasat, Pharm D, PhD[3]; Rodrigo Hasbun, MD, MPH[4] and Shu-Hua Wang, MD, MPH, PharmD[1]; [1]Division of Infectious Disease, The Ohio State University Wexner Medical Center, Columbus, Ohio, [2]Department of Pharmacy, The Ohio State University Wexner Medical Center, Columbus, Ohio, [3]Clinical Microbiolgy, The Ohio State University, Columbus, Ohio, [4]Division of Infectious Diseases, University of Texas Health Science Center at Houston, McGovern Medical School, Houston, Texas

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Background. A rapid and accurate meningitis/encephalitis diagnostic test can have a significant clinical impact and improve utilization of antimicrobial agents. The