

**1413. Surveillance of Variant Creutzfeldt Jakob Disease, Based on the Non-confirmatory Diagnostic Criteria of the EU Case Definition, Greece, 2014–2018**

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**Session:** 155. CNS Infections  
 Friday, October 4, 2019: 12:15 PM

**Background.** Variant Creutzfeldt–Jakob disease (vCJD), is a form of CJD associated with consumption of tissues from cattle infected with bovine spongiform encephalopathy. Confirmation requires cerebral histopathologic examination, ascertaining spongiform change and extensive prion protein deposition with florid plaques. In Greece, the disease has been included in the Mandatory Notification System since 2004 however no reference laboratory has been available since 2009 due to low global occurrence. In 2014, the surveillance system was strengthened to also include possible and probable cases based on the non-confirmatory diagnostic criteria of the EU case definition. Hereby we present the results of the surveillance for 2014–2018.

**Methods.** A new reporting form for CJD was introduced at the national level, including fields aligned with EU case definition criteria for vCJD (preconditions, clinical, diagnostic, and epidemiological). The non-confirmatory diagnostic criteria for the classification of probable and possible vCJD cases were based on examinations routinely available at hospitals, namely EEG and cerebral MRI. Reported CJD cases were assessed according to the fulfillment of required combinations of EU criteria for possible, probable, and confirmed vCJD cases.

**Results.** From 2014 to 2018, 37 CJD cases were reported, with a median age of 67 years (IQR: 58–73) concerning mostly females (71.3%, 95% CI: 56.7–85.9%). Among the reported cases, 6 (16.2%) fulfilled only the preconditions, 8 (21.6%) fulfilled the preconditions and the clinical criteria, 21 (56.8%) had a compatible EEG, and 7 (18.9%) had a compatible MRI brain scan. Confirmatory examination was not performed to any of the CJD cases; however, no case was classified as possible or probable vCJD based on the EU case definition.

**Conclusion.** Notification of CJD patients from 2014 to 2018 in Greece, yielded no vCJD cases. The possible re-emergence of vCJD renders continuous surveillance of the disease imperative. Current EU case definition can support the surveillance of vCJD, by screening CJD patients for possible and probable vCJD cases with the utilization of conventional diagnostic examinations, available in most hospitals.

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

**1414. Time-to-Completed-Imaging, Survival, and Function in Patients with Spinal Epidural Abscess: Description of a Series of 34 Patients, 2015–2018**

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**Session:** 155. CNS Infections  
 Friday, October 4, 2019: 12:15 PM

**Background.** Spinal epidural abscess (SEA) is a rare and life-threatening infection with increased incidence over the past two decades. Delays in diagnosis cause significant morbidity and mortality among patients. The objective of this study was to describe average time-to-imaging and frequencies of intervention, risk factors, and outcomes among patients with SEA presenting to an emergency department at a single academic health center in Portland, Oregon.

**Methods.** This retrospective cohort study reviewed data from patients with no prior history of SEAs at a single hospital from October 1, 2015 to April 1, 2018. We report measures of central tendency and frequencies of collected information.

**Results.** Of the 34 patients included, seven (20%) died or were discharged with plegia during the study period. Four others (11.8%) had motor weakness, and four (11.8%) patients had new bowel or bladder dysfunction at discharge. Those who died or were discharged with plegia ( $n = 7$ ) had shorter mean time-to-imaging order (20.8 hours vs. 29.2 hours). Patients with a history of intravenous drug use had a longer mean time-to-imaging order (30.2 hours vs. 23.7 hours) vs. those without a history of intravenous drug use. Furthermore, only three (42.9%) of the seven patients who died or acquired plegia presented with the three symptom classic triad of SEA: (1) fever; (2) abnormal neurologic examination or symptoms; and (3) neck or back pain.

**Conclusion.** SEA is a potentially deadly infection requiring prompt identification and treatment. This research provides baseline data for potential quality improvement work at the study site. Future research should evaluate multi-center approaches for identifying and intervening to treat SEA, particularly among patients with a history of intravenous drug use.

Table 1. Demographics of patients diagnosed with spinal epidural abscess in a retrospective cohort study at Oregon Health & Science University, 2015-2018

	Plegia or death (n=7)	No plegia or death (n=27)
Age	55.1 (16.2)	49.2 (15.5)
Sex Female	3 (42.9)	10 (37.0)
Race White	5 (71.4)	23 (85.2)
African-American	0	2 (7.4)
Asian	1 (14.3)	0
American Indian/Alaska Native	0	0
Other/declined	1 (14.3)	2 (7.4)
Insured	5 (71.4)	24 (88.9)
Any Medicare	3 (42.9)	8 (29.6)
Any Medicaid	1 (14.3)	2 (7.4)
Private insurance	0	1 (3.7)
No insurance	0	7 (25.9)
Military insurance	0	7 (25.9)
Fever in first 24 hours	4 (57.1)	17 (63.0)
Back or neck pain in first 24 hours	7	23 (85.2)
Paresthesia, focal weakness or abnormal neuro exam in first 24 hours	6 (85.7)	18 (66.7)
Intravenous drug use	2 (28.6)	18 (66.7)
Alcohol use disorder	2 (28.6)	4 (14.8)
Seen by healthcare facility in 72 hours prior to presentation	2 (28.6)	7 (25.9)
Left against medical advice in previous 72 hours	1 (14.3)	1 (3.7)
HIV/AIDS	0	1 (3.7)
Homeless	1 (14.3)	7 (25.9)

Table 2. Table of patients presenting with combinations of fever, back or neck pain, or abnormal neurologic exam in the first 24 hours of care for spinal epidural abscess, 2015-2018

	Plegia or death (n=7)	No plegia or death (n=27)
Fever only	4 (57.1)	17 (63.0)
Back or neck pain only	7	23 (85.2)
Abnormal neuro exam only	6 (85.7)	18 (66.7)
Fever and back/neck pain	4 (57.1)	16 (59.3)
Fever and abnormal neuro exam	3 (42.9)	11 (40.7)
Back/neck pain and abnormal neuro exam	6 (85.7)	14 (51.9)
Fever, back/neck pain and abnormal neuro exam	3 (42.9)	10 (37.0)

Table 3. Interval imaging times in hours for patients with spinal epidural abscess in a retrospective cohort study at Oregon Health & Science University, 2015-2018

Time from:	Plegia or death (n=7)	No plegia or death (n=27)
ED presentation to imaging order	20.8 (37.0)	29.2 (44.9)
Imaging order to imaging completed	11.5 (8.6)	14.2 (23.3)
Imaging completed to final imaging read	20.9 (33.6)	7.14 (7.3)
Final imaging read to surgical intervention (n=5 for plegia/died, n=19 for survived)	4.9 (9.4)	46.2 (52.1)

Table 4. Culture results from patients with spinal epidural abscess with and without a history of intravenous drug use in a retrospective cohort study at Oregon Health & Science University, 2015-2018

	History of intravenous drug use (n=20)	No history of intravenous drug use (n=14)
Aggregatibacter aphrophilus	1 (5.0)	0
Staphylococcus aureus	4 (20.0)	5 (35.7)
Methicillin-resistant Staphylococcus aureus	7 (35.0)	1 (7.1)
Propionibacterium acnes	1 (5.0)	0
Streptococcus pyogenes	0	1 (7.1)
No growth	2 (10.0)	1 (7.1)
No culture	6 (30.0)	4 (28.6)

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

**1415. Use of Adjunctive Steroids in Adults with Encephalitis**

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**Session:** 155. CNS Infections  
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**Background.** To describe the use and the impact on clinical outcomes of adjunctive steroids in adults with encephalitis.

**Methods.** We conducted a retrospective observational study of 230 adults (age >17 years) who met the international consortium definition for encephalitis. An adverse clinical outcome was defined as a Glasgow outcome score of 1–4. The study took place at three tertiary care hospitals in Houston TX, between August 2008 and September 2017.

**Results.** A total of 230 adults with encephalitis were enrolled, out of which 121 (52.6%) received steroids. Adjunctive steroids were given more frequently to those with focal neurological deficits ( $P = 0.013$ ), had a positive cerebrospinal fluid (CSF) HSV PCR ( $P = 0.013$ ), required mechanical ventilation (MV) ( $P = 0.011$ ), required intensive care unit (ICU) admission ( $P < 0.001$ ), had white matter abnormalities ( $P = 0.014$ ) or had cerebral edema on the brain magnetic resonance imaging (MRI) ( $P = 0.003$ ). An adverse outcome was seen in 139 (60.7%) of patients. Predictors for adverse outcomes included a Glasgow coma score (GCS) < 8, fever, seizures, ICU admission, and presence of edema on brain MRI. The use of adjunctive steroids did not impact clinical outcomes ( $P = 0.521$ ). Independent prognostic factors on logistic regression analysis were edema on brain MRI (7.780 [1.717–35.263]  $P = 0.008$ ), GCS < 8 (6.339 [1.992–20.168]  $P = 0.002$ ), and fever (2.601 [1.342–5.038]  $P = 0.005$ ).

**Conclusion.** Adults with encephalitis continues to be associated with significant adverse clinical outcomes in the majority of patients. Adjunctive steroids are used in the sicker patients and it is not associated with improved clinical outcomes.

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

**1416. Nocardia beijingensis: A Rare and Unusual Cause of Intracranial Abscess**

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**Session:** 155. CNS Infections  
 Friday, October 4, 2019: 12:15 PM

**Background.** Nocardia species are thin, aerobic, filamentous, gram-positive bacilli that are ubiquitous in soil worldwide. Nocardia infections are divided into three