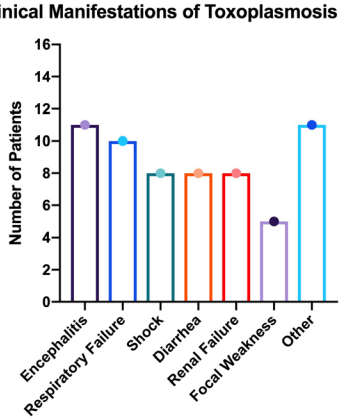
failure (63%), renal failure (50%), diarrhea (50%), and septic shock (50%). The estimated all-cause 30-day and 90-day mortality rates were 56% and 69%, respectively.

Conclusion: Toxoplasmosis has diverse presentations in transplant recipients, likely contributing to diagnostic delays and high mortality. Future study is needed to determine clinical scenarios and risk factors where donor and recipient serologic screening may beneficial.

Table 1. Baseline characteristics and outcomes of 16 transplant recipients from Emory Healthcare and Duke University Hospital

Patient Characteristics	**n (%)**
Median Age (IQR)	56 (46 - 67)
Sex	
Females	8 (50)
Race	
White	10 (63)
Black	5 (31)
Other	1 (6)
Transplant Type	
HSCT	7 (44)
SOT	9 (56)
DDRT	5 (31)
OHT	2 (13)
Lung	1 (6)
SKP	1 (6)
Time from transplant to toxoplasmosis diagnosis in days	**n (IQR)**
All patients	295 (57 - 2,160)
SOT	1,595 (304 - 6,187)
HSCT	54 (47 – 2,019)
Diagnostic Modality	**n (%)**
PCR	10 (63)
Pathology	5 (31)
Other	1 (6)
Clinical Presentation	**n (%)**
Encephalitis	11 (69)
Respiratory Failure	10 (63)
Septic Shock	8 (50)
Renal Failure	8 (50)
Diarrhea	8 (50)
Focal Weakness	5 (31)
Outcome	**n (%)**
30-day mortality	9 (56)
90-day mortality	11 (69)

Abbreviations: IQR: Interquartile range; HSCT: Hematopoietic stem cell transplant; SOT: solid organ transplant; DDRT: Deceased donor renal transplant; OHT: orthotopic heart transplant; SKP: Simultaneous kidney pancreas transplant



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

2694. Incidence of *Pneumocytis jiroveci* (PJP) Infection with 3-Month Prophylaxis of Aerosolized Pentamidine (AP) in Autologous Hematopoietic Stem Cell Transplantation (HSCT)

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Background: HSCT patients are at an increased risk of developing PJP after transplant due to treatment induced immunosuppression. Given the risk of cytopenias with co-trimoxazole, AP is utilized as an alternative for PJP prophylaxis. A prior study revealed a 0% (0/19 patients) incidence when AP prophylaxis was given for one year post autologous HSCT. Current guidelines recommend a duration of 3 – 6 months for PJP prophylaxis in autologous HSCT. The primary endpoint of this study was to assess the incidence of PJP infection within one year post autologous HSCT in patients who received 3 months of AP. Secondary endpoint was a cost comparison of 3 months compared with 6 months of AP.

Methods: A single-center, retrospective study of adult autologous HSCT patients at Yale New Haven Hospital between February 2013 and December 2017 was performed. Patients were excluded if: <18 years of age, received < or >3 months of AP, changed to alternative PJP prophylactic agent or received no PJP prophylaxis, received tandem HSCT, deceased prior to one year post-transplant from a non PJP-related infection, HIV positive, or lost to follow-up. Pentamidine was given as a 300 mg inhalation monthly for 3 months starting Day +15 after autologous HSCT.

Results: A total of 288 patients were analyzed, no PJP infections occurred within one year post HSCT. Additionally, 187 (65%) patients received treatment post HSCT with 135/215 (63%) receiving maintenance immunomodulatory drugs for myeloma and 40/288 (14%) patients developing relapsed disease. 43% of the chemotherapy regimens for relapsed disease included high dose corticosteroids. The cost difference of using 3 months vs. 6 months of AP is $790, reflecting the cost of drug and its administration. Applying our incidence of 0%, potential cost savings of 3 months vs. 6 months of AP would be $330,000 over 5 years or $66,000 per year.

Conclusion: Three months of AP for PJP prophylaxis in autologous HSCT patients is safe and effective as well as cost-effective compared with a 6 month regimen.

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

2695. *Pneumocystis jirovecii* Pneumonia in the Era of Effective Prophylaxis Following Hematopoietic Stem Cell Transplant

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