Table 3. Clinical Outcomes

	Cephalexin (n=46)	Levofloxacin (n=36)	P-value
Composite Outcome, n (%)	2 (4.3%)	0	0.50
60-day mortality	1 (2.2%)	0	1
60-day readmission related to bacteremia	1 (2.2%)	0	1
Secondary Outcomes			
Emergence of gram-negative resistance, n (%)	3 (6.5%)	0	0.25
Subsequent *C. difficile* infection, n (%)	0	0	--
Hospital LOS (days), median (IQR)	5 (4-5)	5 (4-6)	0.26

Conclusion: Patients who received cephalexin or levofloxacin did not have a significant difference in the composite primary outcome. These findings suggest that oral cephalexin is an effective step-down option to treat uncomplicated GNR bacteremia.

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279. Dalbavancin for Bloodstream Infections and Endocarditis: Real-World Outcomes From the DRIVE Registry

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Session: P-9. Bacteremia

Background: Dalbavancin, a long-acting lipoglycopeptide approved by the US FDA and EMA for acute bacterial skin and skin structure infections (ABSSSI) has potent activity against Gram-positive pathogens including MRSA. A total of 39 of 39 patients with baseline *S aureus* bacteremia from previous studies who received dalbavancin (1500 mg or 1000 mg followed by 500 mg 1 week later) had clearance of bacteremia (100%). We describe the clinical features and efficacy of dalbavancin in patients with bacteremia or endocarditis from a retrospective registry study of dalbavancin.

Methods: Dalvance Utilization Registry Investigating Value and Efficacy (DRIVE) was a phase 4 observational, multicenter, retrospective cohort study of the real-world use of dalbavancin in adults across the US. Data collected between 03/25/2017 and 11/27/2018 included patient, disease, and pathogen characteristics, antibiotic use, clinical outcome, and safety. Clinical outcome was assessed by chart review from last dalbavancin dose through 60 days. Success was defined as presumed or documented clinical or microbiological cure with no need for rescue IV antibiotic therapy. Failure was defined as presumed or documented clinical or microbiologic failure, or the need for rescue IV antibiotic therapy, or death. Outcome was indeterminate if there were insufficient data to determine status at 60 days.

Results: Of 1092 evaluable patients treated with dalbavancin for any indication, 32 had baseline bloodstream pathogen data and Gram-positive bacteremia (Figure). 29 of 32 patients were previously treated with antibiotics (91%) with a median duration of 8.5 days. The 3 patients with endocarditis were among those most heavily pretreated (9, 4, and 4 prior IV antibiotics each). Clinical success was achieved in 30/32 (94%); outcome was indeterminate in 2/32 (6%). Most common dalbavancin regimens were 1500 mg x 1 (50%) or 1500 mg weekly x 2 (13%). Negative blood cultures for baseline pathogen prior to dalbavancin were documented in 53% of patients. There were no adverse events assessed as related to dalbavancin.

Conclusion: Dalbavancin use in Gram-positive bacteremia appears well tolerated and effective in the real-world setting.

Figure: Baseline Characteristics in Patients with Gram-positive Bacteremia

	Dalbavancin n=32
Bloodstream pathogen at baseline	
Staphylococcus aureus	31 (97%)
MRSA	16 (50%)
MSSA	15 (47%)
Streptococcus parasanguinis	1 (3%)
Definite infective endocarditis by modified Duke Criteria	3 (9%)
Presumed source of bacteremia / risk factors*	
ABSSSI	16 (50%)
Injection drug use	12 (38%)
Indwelling/invasive/prosthetic device	10 (31%)
Unknown	2 (6%)
Hemodialysis fistula	1 (3%)
Intravenous line	1 (3%)
Prior antibiotics (most common)*	
Vancomycin	23 (72%)
Daptomycin	10 (31%)
Cefazolin	9 (28%)
MRSA: methicillin-resistant *Staphylococcus aureus*. MSSA: methicillin-susceptible *Staphylococcus aureus*. ABSSSI: Acute bacterial skin and skin structure infection. Data are presented as No. (%). *Categories are not mutually exclusive.	

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280. Description of Transesophageal Echocardiography Prescribing Practices in non-*Staphylococcus aureus* Bacteremia with Application of Scoring Systems

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Session: P-9. Bacteremia

Background: In non-*S. aureus* gram-positive bacteremia (non-SAB), practices of obtaining transesophageal echocardiography (TEE) are mixed despite the availability of scoring systems in certain organisms (DENOVA for *E. faecalis*, HANDOC for non-beta hemolytic streptococci) that provide recommendations for TEE with scores 3 or higher. This study aimed to analyze the application of DENOVA and HANDOC scoring systems to coagulase-negative *Staphylococci* (CoNS), *Enterococcus* spp. and *Streptococcus* spp. in relation to TEE prescribing practices.

Methods: A retrospective, observational study was conducted at two tertiary care hospitals including patients with ≥1 positive blood culture for *Enterococcus* spp. or *Streptococcus* spp., or ≥2 positive blood cultures for CoNS with matching susceptibilities between November 2017 and November 2019. The primary outcome compared DENOVA and HANDOC scores in patients who received TEE vs. those who did not. Secondary outcomes included DENOVA and HANDOC scores in subgroup populations, adherence to DENOVA/HANDOC scoring systems, treatment characteristics, and patient outcomes.

Results: Of the 310 patients included, 96 (31%) underwent TEE and 214 (69%) did not. Fewer patients in the TEE group underwent transthoracic echocardiography: 29.2% vs. 69.9%, p< 0.01. Infectious Diseases providers were involved in all patients that underwent TEE. Median scores were significantly higher in all patients who underwent TEE; DENOVA: 2 (1–3) vs. 1 (1–2), p< 0.01; HANDOC: 3 (3–4) vs. 3 (2–3), p< 0.01. DENOVA and HANDOC scores were significantly higher in the TEE group in *Enterococcus* spp. and *Streptococcus* spp., respectively; overall adherence to scoring system recommendations in these groups was less than 60%. HANDOC score was higher in the TEE group for patients with CoNS and 87.5% of these patients with score ≥3 had endocarditis (versus 50% with DENOVA score). More patients in the TEE group had endocarditis 46.9% vs. 6.5%, p< 0.01.

Conclusion: DENOVA and HANDOC scores were significantly higher among TEE patients, but areas of improvement exist in relation to overutilization of TEE and development of scoring system for CoNS. Efforts to improve TEE utilization should be coordinated with Infectious Disease providers.

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281. Detecting bacterial sepsis among allogeneic HCT recipients with population-specific bedside tools

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Session: P-9. Bacteremia

Background: Diagnosing sepsis among allogeneic hematopoietic cell transplant (aHCT) recipients remains challenging. Existing criteria, for use in hospitalized patients, have limited predictive accuracy among aHCT recipients and their use may lead to missed events or antibiotic overuse. We developed bedside bacterial sepsis prediction tools (criteria and decision tree [DT]) for aHCT recipients and compared them against Systemic Inflammatory Response Syndrome (SIRS), quick Sequential Organ Failure Assessment (qSOFA) and National Early Warning Score (NEWS) criteria.

Methods: Adult aHCT recipients transplanted between September 2010–2019 with ≥ 1 potential infection (PI) within 100 days post-transplantation were randomly assigned to model/validation (7/3) cohorts. Tools included demographic and clinical factors and were built against a bacterial sepsis endpoint (gram-negative, *Staphylococcus aureus*, or *Streptococcus* species bacteremia). The tools were developed using best subset selection with rare event logistic regression (criteria) and classification tree (DT) algorithms. Criteria scores were estimated using a beta/10 integer weighting approach and tool predictive performances were compared against existing criteria.

Results: Between September 2010–2019, 1571 recipients with ≥ 1 PI contributed 7755 PIs and 238 sepsis events. The DT model included 7 terminal nodes based on 3 predictors: temperature, respiratory rate (RR), and sex. The criteria model contained 10 categories with 4 predictors: RR, temperature, pulse, and diastolic blood pressure (Figure 1). Our criteria and DT had AUCs of 71.1% (95% Confidence Interval: 64.3, 77.9%) and 70.0% (CI: 63.7, 76.2%). SIRS had the highest AUC of existing criteria – 64.7% (CI: 57.1, 71.9%). Our criteria had the highest net benefit (for probabilities < 10%) and, at a 7+ cut-point, had a sensitivity of 73.8% (CI: 61.5–84.0%) and specificity of 55.0% (CI: 52.9, 57.1%) (Figure 2).