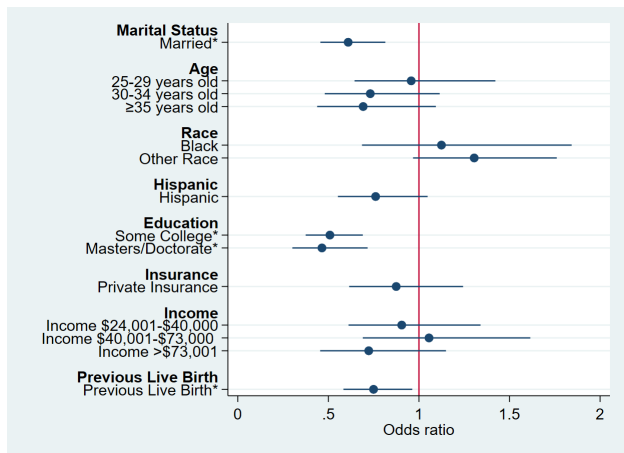


Figure 1: Adjusted Odds of Having Received Pre-pregnancy STI Counseling among Recent Mothers, RI PRAMS 2016-2018 (n=2,361)



*P-value <0.05

Reference Group; Marital Status: unmarried, Age: < 25 years old, Race: White, Hispanic: Non-Hispanic, Education: High school degree or less, Insurance: Public insurance, Income: < \$24,000, Previous live birth: No previous live birth

Conclusion. Selective STI counseling creates gaps and missed opportunities to address STIs early before pregnancy. All women regardless of their perceived risk for STI or assumptions based on their marital status should receive proper STI counseling as all women are vulnerable and at higher risk of developing complications. Health care providers should increase efforts to address this gap and counsel all women about STIs during every visit irrespective of their marital status.

Disclosures. All Authors: No reported disclosures

1357. Patterns of Extragenital Gonorrhea and Chlamydia Testing at a Community-Based Academic Emergency Department in Columbus, Ohio

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Session: P-75. Sexually Transmitted Infections

Background. Sexually transmitted infections (STI), including gonorrhea (GC) and chlamydia (CT), are on the rise in the U.S. and emergency department (ED) visits for STI-related complaints are common. The ED plays a key role in testing for GC/CT. In addition to testing genital sites for GC/CT, the Centers for Disease Control and Prevention (CDC) recommends extragenital testing (oral/rectal) based on sexual history and exposure. In this study, we reviewed the proportion of extragenital GC/CT tests performed at a community-based academic ED in Columbus, Ohio.

Methods. This study was a retrospective chart review of all GC/CT tests performed at the Ohio State University Hospitals East ED from November 1, 2018 to November 1, 2020. Clinical and demographic information was collected for all patients who received extragenital GC/CT testing, including symptoms, test results, and documentation of sexual practices. A random convenience sample of 100 patients who only had genital GC/CT testing performed was also reviewed.

Results. Of the 5644 GC/CT tests performed during the study period, only 364 (6.4%) were from extragenital sites, which included 311 (5.5%) from oral and 53 (< 1%) from rectal sites. Of the 100 patients reviewed who did not have extragenital GC/CT testing performed, only 5 (5%) had documentation of sexual practices, compared with 177/311 (56.9%) of those who had oral testing and 27/31 (50.94%) who had rectal testing performed. In the cohort of 100 patients who did not receive extra genital testing 28% were male and average age was 29. In the group who received extragenital testing 40% were male and average age was 30. The most common complaint across all groups was genital discharge

Conclusion. Despite the substantial number of CG/CT tests performed in the ED, only a very small proportion were from extragenital sites. Interventions are needed to identify and overcome barriers to extragenital GC/CT testing in the ED.

Disclosures. Mohammad Mahdee Sobhanie, M.D., Regeneron (Scientific Research Study Investigator)Regeneron (Scientific Research Study Investigator, Was a sub-investigator for Regeneron 2066 and 2069) Carlos Malvestutto, M.D., Lilly (Scientific Research Study Investigator)Regeneron Inc. (Scientific Research Study Investigator)ViiV Healthcare (Advisor or Review Panel member)

1358. A Real-World Study of the Burden of Illness and Treatment Patterns Among Patients with Uncomplicated Urogenital Gonorrhea in the United States

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Session: P-75. Sexually Transmitted Infections

Background. Gonorrhea (GC) is a major public health threat in the US. The Centers for Disease Control and Prevention (CDC) estimated direct healthcare costs of \$271 million in 2018. CDC 2015 guidelines (applicable up to December 18, 2020) recommended cephalosporin plus azithromycin for GC. We used real-world data to assess patterns of inappropriate or suboptimal (IA/SO) or appropriate and optimal (AP&OP) antibiotic (AB) prescription (by CDC 2015 guidelines), and related healthcare costs, in US patients with uncomplicated urogenital GC (uUGG) diagnosed from July 1, 2013–June 30, 2018.

Methods. A retrospective cohort study of IBM MarketScan data (commercial/Medicare claims) in patients ≥ 12 years old with uUGG. Eligible patients had an AB prescription ±5 days of uUGG diagnosis (index date) and continuous health-plan enrollment with ≥ 6 months' baseline/≥ 12 months' follow-up data. Patients with complicated urogenital GC were excluded. Patients were stratified by AB prescription (IA/SO or AP&OP; defined in Table 1) during the first uUGG episode (ie, within 30 days of index). Generalized linear models were used for multivariate analysis.

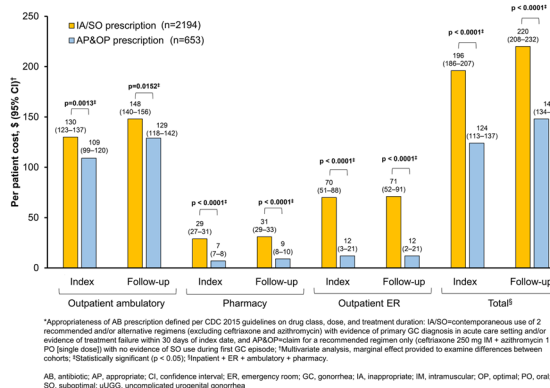
Table 1. Definitions of appropriateness of AB prescriptions

AB prescription	Definition
IA	Contemporaneous use of 2 recommended and/or alternative regimens (per CDC 2015 guidelines), with the exception of ceftriaxone and azithromycin
SO	Evidence of primary GC diagnosis in acute care setting (ER/inpatient stay within 30 days of initial gonorrhea diagnosis) Evidence of treatment failure (re-treatment within 30 days of index)
AP&OP	Per CDC 2015 guidelines on drug class, dose, and treatment duration Ceftriaxone 250 mg IM + azithromycin 1 g PO (single dose) Claim for a recommended regimen only Patients without evidence of SO AB use in the first 30 days after the index date

AB, antibiotic; AP&OP, appropriate and optimal; CDC, Centers for Disease Control and Prevention; ER, emergency room; GC, gonorrhea; IA, inappropriate; IM, intramuscular; PO, oral; SO, suboptimal

Results. Of 2847 patients with uUGG (58.5% male), 77.1% had an IA/SO prescription (mostly due to IA AB class [~82.0%] and duration [24.0%]), while only 22.9% had an AP&OP prescription; uUGG episodes were more frequent with IA/SO (n=2386) than AP&OP (n=714) prescriptions during follow-up. Patients with IA/SO prescriptions had higher GC-related total adjusted costs per patient (PP) per index episode (\$196) vs those with AP&OP prescriptions (\$124, p < 0.0001; Figure). Patients with IA/SO prescriptions also had higher GC-related total adjusted costs PP during follow-up (\$220) vs those with AP&OP prescriptions (\$148, p < 0.0001), mostly driven by higher outpatient ambulatory and emergency room (ER) adjusted costs with IA/SO (\$148 and \$71, respectively) vs AP&OP prescriptions (\$129 and \$12, respectively, p < 0.0152; Figure). ER visits PP at index and during follow-up were higher with IA/SO vs AP&OP prescriptions (p < 0.0001; Table 2).

Figure. GC-related costs per patient with uUGG, stratified by appropriateness of AB prescription*



*Appropriateness of AB prescription defined per CDC 2015 guidelines on drug class, dose, and treatment duration: IA/SO=contemporaneous use of 2 recommended and/or alternative regimens (excluding ceftriaxone and azithromycin) with evidence of primary GC diagnosis in acute care setting and/or evidence of treatment failure within 30 days of index date, and AP&OP=claim for a recommended regimen only (ceftriaxone 250 mg IM + azithromycin 1 g PO [single dose]) with no evidence of SO use during first GC episode; *Multivariate analysis, marginal effect provided to examine differences between cohorts; *Statistically significant (p < 0.05); †Inpatient + ER + ambulatory + pharmacy.

AB, antibiotic; AP, appropriate; CI, confidence interval; ER, emergency room; GC, gonorrhea; IA, inappropriate; IM, intramuscular; OP, optimal; PO, oral; SO, suboptimal; uUGG, uncomplicated urogenital gonorrhea

Table 2. GC-related HRU per patient with uUGG, stratified by AB prescription

Per patient HRU*	All patients (n=2194)		p-value
	IA/SO prescription ¹ (n=2194)	AP&OP prescription ² (n=653)	
Index GC episode			
Ambulatory visits, n (95% CI)	0.98 (0.94–1.03)	1.07 (0.98–1.15)	0.0648
Pharmacy claims, n (95% CI)	0.57 (0.53–0.60)	0.78 (0.71–0.85)	
Outpatient ER visits, n (95% CI)	0.08 (0.07–0.10)	0.02 (0.02–0.04)	
Patients with ambulatory visits, % (95% CI)	89.22 (87.82–90.47)	98.93 (97.77–99.49)	< 0.0001†
Patients with pharmacy claims, % (95% CI)	49.27 (47.16–51.39)	77.11 (73.71–80.18)	
Patients with outpatient ER visits, % (95% CI)	8.04 (6.84–9.42)	2.33 (1.45–3.71)	
1-year follow-up period (Index + follow-up episodes)			
Ambulatory visits, n (95% CI)	1.08 (1.01–1.14)	1.15 (1.07–1.24)	0.0403†
Pharmacy claims, n (95% CI)	0.59 (0.56–0.63)	0.83 (0.78–0.89)	
Outpatient ER visits, n (95% CI)	0.08 (0.07–0.10)	0.02 (0.02–0.04)	
Patients with ambulatory visits, % (95% CI)	89.68 (88.33–90.92)	98.92 (97.76–99.49)	< 0.0001†
Patients with pharmacy claims, % (95% CI)	49.80 (47.69–51.92)	77.69 (74.32–80.73)	
Patients with outpatient ER visits, % (95% CI)	8.16 (6.96–9.55)	2.34 (1.46–3.73)	

*Multivariate analysis, marginal effect provided to examine differences between cohorts; ¹Appropriateness of AB prescription defined per CDC 2015 guidelines on drug class, dose, and treatment duration: IA/SO=contemporaneous use of 2 recommended and/or alternative regimens (excluding ceftriaxone and azithromycin) with evidence of primary GC diagnosis in acute care setting and/or evidence of treatment failure within 30 days of index date, and AP&OP=claim for a recommended regimen only (ceftriaxone 250 mg IM + azithromycin 1 g PO [single dose]) with no evidence of SO use during first GC episode; *Statistically significant (p < 0.05)

AB, antibiotic; AP, appropriate; CI, confidence interval; ER, emergency room; GC, gonorrhea; HRU, healthcare resource use; IA, inappropriate; IM, intramuscular; OP, optimal; PO, oral; SO, suboptimal; uUGG, uncomplicated urogenital gonorrhea

Conclusion. Most patients with uUGG were not prescribed treatments in accordance with CDC 2015 guidelines. High IA/SO AB prescriptions and associated

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