CZA resistance development was not detected. Three patients (5.9%) experienced infection recurrence within 30 days of completing therapy.

Conclusion. The use of CZA was associated with high rates of favorable outcomes in complex patients with MDR PA infections. Future studies evaluating long-term outcomes and comparative studies are needed to more precisely define the role of CZA for MDR PA infections.

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2255. The Use of Dalbavancin for *Staphylococcus aureus* Bacteremia in Persons Who Inject Drugs (PWID)

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Session: 246. Clincal Outcomes of Infections with Resistant Organisms
Saturday, October 5, 2019: 12:15 PM

Background. *Staphylococcus aureus* is a significant cause of bacteremia and is associated with high morbidity and mortality rates. In patients with *S. aureus* bacteremia, studies have proven that intravenous antibiotics are needed for the entire course of therapy. For some groups of patients, specifically in persons who inject drugs (PWID), the long-term use of IV antibiotics is not safe or feasible. In this population, the current options would be obtaining intravenous access daily for antibiotic infusions, oral antibiotics, or being admitted to a facility that can monitor the patient. Data concerning the utilization of dalbavancin for the treatment of *S. aureus* bacteremia are limited.

Methods. This was a multicenter, retrospective case series of patients treated with four to six weekly doses of dalbavancin at 5 infusion centers in 3 states under the care of Metro Infectious Disease Consultant (MIDC) physicians between January 1 and December 31, 2018. All patients received intravenous therapy through a peripherally inserted catheter that was removed immediately after the infusion was completed. All patients were evaluated by an MIDC physician at the time of the initial dalbavancin dose, and weekly through their course of therapy. Cure was defined as negative blood cultures and no clinical evidence of persistent or relapsing infection. All patients completed their prescribed dosing and had phone follow-up to assess treatment efficacy at weeks 4, 8, 12, and 24.

Results. Twenty-one patients were included in the analysis. All patients began therapy for *S. aureus* bacteremia as inpatients and were transitioned to dalbavancin as outpatients. All patients received dalbavancin 1 g followed by 500 mg doses for at least 3 more weeks with an average of 4 weeks of therapy. Of the 21 patients, 16 were able to be contacted post therapy. Of the 16 patients, 2 patients were readmitted within the 6 month time frame for recurrent bacteremia related to intravenous drug usage. The remaining 14 patients remained disease free at the 6 month interval. No patients experienced a line related issue or *C. difficile* infection during the course of therapy.

Conclusion. Use of dalbavancin to treat *S. aureus* bacteremia infections resulted in clinical cure and markedly decreased healthcare costs.

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

2256. Baloxavir Marboxil in Combination with Oseltamivir in Two Critically Ill Patients with Influenza A (H1N1; 2009 strain) on Veno-Venous Extra-Corporal Membranous Oxygenation

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Session: 246. Clincal Outcomes of Infections with Resistant Organisms
Saturday, October 5, 2019: 12:15 PM

Background. Currently, there are no clinical data regarding the use of baloxavir marboxil in patients with complicated influenza infection. A study in a mouse model of influenza A infection suggested that there may be a potential benefit of combination therapy with neuraminidase inhibitors. We present the first reported use of baloxavir marboxil in combination with oseltamivir in two critically ill patients requiring veno-venous extracorporeal membrane oxygenation (VV-ECMO) support due to severe acute respiratory distress syndrome (ARDS) caused by influenza AH1N1 2009.

Methods. Cases: (1) 56-year-old man with a history of coronary artery disease who was vaccinated for flu this season, presented with 5 days of cough and dyspnea and required cannulation for VV-ECMO due to severe ARDS. He was placed on continuous renal replacement therapy (CRRT) for renal failure as well as vasopressor and inotropic support. Bronchoalveolar lavage (BAL) polymerase chain reaction (PCR) was positive for Influenza A H1N1 2009 strain. He received a dose of baloxavir 80 mg on Day 1 and a 7-day course of oseltamivir which was started on Day 0. Influenza PCR testing obtained 5 days after receipt of baloxavir was negative. The patient was decannulated on hospital day 7 and extubated at 14 days. (2) 50-year-old man with a history of hypertension and dyslipidemia who was not flu vaccinated, presented with symptoms of cough and dyspnea for 3 days. He was cannulated due to severe ARDS. He required CRRT for renal failure. BAL PCR tested positive for Influenza A H1N1 2009 strain. He was given two 80 mg doses of baloxavir on hospital days 1 and 5 and treated with oseltamivir for 10 days. Despite a negative PCR test for influenza on day 15, the patient remained critically ill on ECMO with multisystem organ failure.

Results. -

Conclusion. We describe the first reported clinical use of baloxavir in combination with oseltamivir for influenza A H1N1 infection in two critically ill patients with respiratory failure requiring VV ECMO. Further pharmacokinetic/pharmacodynamic analysis is needed to determine optimal dosing in critically ill patients, and those requiring CRRT. Baloxavir synergy with the neuraminidase inhibitors may be of benefit in critically ill patients, and additional prospective clinical study is needed.

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2257. BDG-Guided Management of Empirical Antifungal Therapy: a Real-life Experience in a Hospital-Wide Context with High Incidence of Non-albicans Candida Infection

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Session: 246. Clincal Outcomes of Infections with Resistant Organisms
Saturday, October 5, 2019: 12:15 PM

Background. BDG-guided management of empirical antifungal therapy (AT) has been suggested as a tool to rule out invasive candidiasis (IC) and discontinue AT in critically ill patients. However, some authors reported lower BDG sensibility for non-albicans *Candida* (NAC) infection. Impact of BDG use in a hospital wide setting has yet to be determined.

Methods. We performed a retrospective observational study of consecutive patients admitted to a 1535-bed teaching hospital from November 2015 to August 2017. Adult patients starting empirical AT and performing at least one BDG test for a suspected fungal infection were included. According to first BDG result and AT management, patients were classified in 3 groups: (G1) negative index BDG and early AT withdrawal; (G2) negative index BDG and AT continued; (G3) positive index BDG and AT continued. IC was defined as monomicrobial *Candida* spp. isolation from blood cultures and/or surgical specimen. Comparison of the 3 groups was made using post-hoc Bonferroni correction. Univariate and multivariate analyses of risk factors for all-cause 30 days mortality were performed using binary logistic regression model.

Results. Study population consisted of 208 patients, of which 46 (22.1%) were included in G1, 79 (38.0%) in G2, and 83 (39.9%) in G3. NAC species were more commonly isolated from patients with IC and negative BDG ($P = 0.005$). IC was diagnosed in 2.2%, 13.9%, and 19.3% of G1, G2, and G3, respectively ($P < 0.01$ for G1 vs. G3). Median AT DDD were 8, 28, and 20 ($P < 0.01$ for G1 vs. G2 and G1 vs. G3) and 30-day mortality rate was 21.4%, 16.5%, and 30.1%, respectively. Factors associated with 30-day mortality were age, Charlson Comorbidity Index (CCI), ICU admission, SOFA score, septic shock, orotracheal intubation, CVVH and index BDG ≥ 80 pg/mL. At multivariate model, independent risk factors for 30-day mortality were CCI (OR 1.4, 95% CI 1.2–1.6, $P < 0.001$), SOFA score (OR 1.2, 95% CI 1.1–1.3, $P < 0.001$) and index BDG≥80 pg/mL (OR 2.4, 95% CI 1.2–4.8, p = 0.012). Model fit was $P = 0.65$ by Hosmer–Lemeshow test and accuracy according with ROC analysis was 0.82 (95% CI 0.76–0.88).

Conclusion. BDG positivity is a strong predictor of poor outcome, but its accuracy for NAC infection may be suboptimal. Caution may be necessary for AT discontinuation based on a negative BDG result in patients at high risk for NAC infection.

Figure 1: Cox regression survival analysis accordind to index BDG result