mean MASCC score of those with CI vs. those without was 16.9 vs. 18.6 ($P = 0.03$) and there was a trend toward higher mean PITT scores for patients with CI by day 8 vs. those without (1.54 vs. 0.82 ($P = 0.08$)). Among GN bacteremias, 15% developed CI vs. 14.5% in nonviridans group Streptococci (VGS) GP bacteremias, and 10.9% in VGS bacteremias (NS). Among patients with single organism bacteremias (88% of all BSI), mismatch of IAR coverage with isolate susceptibilities occurred in 16.7% (38/227). Among patients whom IAR was active vs. inactive against BSI isolate, 16% vs 14.3%, respectively, developed CI ($P = 0.81$).

Conclusion. These data indicate that the MASCC score applied to high-risk inpatients may be a predictor for CI in the first week after bacteremia FN. The PITT shows less correlation with poor outcomes. There was no association between isolate type (GN, GP, or VGS) and CI. Notably there was no association between mismatched BSI susceptibility and antimicrobial spectrum of the IAR and early CI.

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1017. Impact of Enterococcal Bloodstream Infection on Mortality in Patients With Acute Myelogenous Leukemia

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Session: 131. Bacteremia and Endocarditis
Friday, October 5, 2018: 12:30 PM

Background. Though enterococcal bloodstream infection (EBSI) is common in patients with acute myelogenous leukemia (AML), its impact on mortality requires further elucidation. Our objectives were to: (1) determine attributable mortality to EBSI and (2) compare overall, 1-year, relapse-related mortality (RRM), and treatment-related mortality (TRM) between AML patients with and without EBSI.

Methods. This was a retrospective cohort receiving intensive chemotherapy for AML from 2010 to 2015. EBSI was defined by _1 positive blood culture for *E. faecium* or *faecalis* and fever, hypotension, or chills. Attributable mortality to EBSI was defined by failure to achieve BSI Clearance (_1 negative culture _24 hr after last positive culture and defervescence) by the date of death. Student's t-test was used to compare continuous variables, and C^2 test was used for categorical variables. Kaplan–Meier was used for survival analyses (unadjusted), and *P*-values were computed by log-rank.

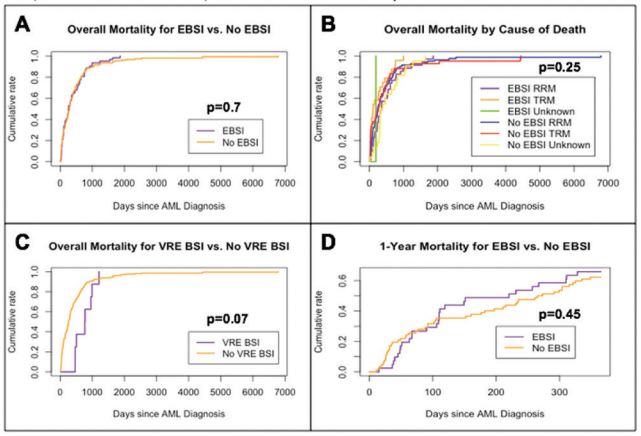
Results. Three hundred eight patients were identified during the study period: 80 with EBSI and 228 without EBSI. 5/80 patients died with EBSI (6%) although 4/5 patients had concurrent infections at the time of death (*Clostridium difficile* colitis, candidemia, proven invasive aspergillosis, and probable invasive fungal disease, respectively). There were no significant differences between overall and 1-year mortality (Table 1). In the survival analyses, EBSI did not significantly impact overall survival, 1-year mortality, RRM, and TRM (Figure 1). However, patients with vancomycin-resistant EBSI (VRE) trended toward increased overall mortality.

Conclusion. Attributable mortality to EBSI is uncommon (6%) in AML. Additionally, EBSI does not significantly impact mortality in this vulnerable patient population that already has very high rates of RRM and TRM. However, as EBSI inflicted 26% of patients over the course of this study period, further investigation is needed to elucidate the morbidity suffered from this common infection and identify potentially modifiable risk factors.

Table 1.

	EBSI $N = 80$ (26%)	No EBSI $N = 228$ (74%)	P
Age AML diagnosis (median years, IQR)	63 (51–69)	61 (50–69)	0.93
Overall mortality (%)	63/73 (86)	154/198 (77)	0.12
Time AML diagnosis to death (median years, IQR)	220 (67–541)	273 (62–582)	0.16

Figure 1: Impact of Enterococcal BSI on Survival in Patients with Acute Myelogenous Leukemia. Days since AML diagnosis were computed from date of AML diagnosis to date of last documented follow-up. 34 patients were lost-to-follow-up and not included in these analyses.



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1018. Prevalence of Bacteremia/Fungemia and Pneumonia in Remission Induction Chemotherapy for Adult Acute Myeloid Leukemia From 1987 to 2005: Japan Adult Leukemia Study Group (JALSG)

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Session: 131. Bacteremia and Endocarditis
Friday, October 5, 2018: 12:30 PM

Background. Remission induction (RI) chemotherapy for acute myeloid leukemia (AML) is one of the most intensive chemotherapy available. Antibiotic prophylaxis and prompt treatment for infectious complications during RI chemotherapy play a major role in supportive care.

Methods. We retrospectively analyzed the infectious complications associated with RI chemotherapy listed in the Japan Adult Leukemia Study Group AML201 protocol, a nationwide study of *de novo* AMLs, conducted between 2001 and 2005 in Japan. Of the 1,057 cases initially included in the AML201 study, 980 cases with data on infectious complications during RI chemotherapy were analyzed. The incidences of infectious complications and the causative pathogens were compared with previous studies [(period A) 1987–1991, 577 cases; (B) 1992–1995, 669 cases; (C) 1995–1997, 531 cases; (D) 1997–2001, 808 cases; (E) 2001–2005, 980 cases].

Results. In study period E, the causative pathogens of bacteremia/fungemia were *Staphylococcus epidermidis* (20.9%), *S. aureus* (11.6%), *Streptococcus* sp. (14.0%), and other Gram-positive bacteria (18.6%); *P. aeruginosa* (12.8%) and other Gram-negative bacteria (10.5%); and fungi (9.3%). Pathogens causing pulmonary infections were *Aspergillus* sp.(15.8%), *P. aeruginosa* (7.9%), and other Gram-negative bacteria (6.9%) and Gram-positive bacteria (3.0%). Pulmonary aspergillosis was diagnosed mainly