Background. In Chile, there is little information on invasive fungal disease (IFD) due to filamentous fungi. A study of our institution showed 41 episodes in hemato oncological patients between the years 2004 and 2008, being the main cause *Aspergillus*, but the epidemiological characteristics of this infection in Chilean patients are not currently known. The objective describes the epidemiology of IFD by *Aspergillus*in our center.

Methods. Retrospective study in adults patients hospitalized in our center, diagnosed with IFD by *Aspergillus* between 2005 and 2015. Medical records of identified cases were review, incidence were calculated with the discharges numbers and total numbers of IFD. The study was approved by the Institutional Ethics Committee.

Results. Sixty-seven cases were identified, with an incidence of 2.53 per 10,000 discharges between 2005 and 2015, with 35 cases of IFD in the period 2005–2010 and 32 cases in the period 2011–2015. The etiologies were *A. fumigatus* 42%, *A. flavus* 7%, *A. terreus* 7%, *A. niger* 3%, and *Aspergillus* spp. 40%. According EORTC/MSG criteria, 39% were proven, 52% probable, and 9% possible. The 55% of patients were male, the mean ± SD age was 51 ± 18 years, 57% had hematological conditions, mainly acute leukemias, rheumatological conditions in 15% and solid organ transplant in 13%, neutropenia under 500/mm^3 in 37% and serum galactomannan test >0.5 in 67%. The clinical focus was 73% pulmonary and 17% rhinosinusal. The treatment was 81% monotherapy, 73% with voriconazole, 15% with liposomal amphotericin B and 6% with caspofungin. The 30 days mortality was 39%.

Conclusion. The epidemiology of IFD by *Aspergillus* is similar to that described in developed countries, in highly vulnerable patients with a mortality close to 40%. More epidemiological information from other hospitals is necessary to complete the epidemiology of *Aspergillus* infections in our country.

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

187. Candidemia with Ocular Manifestrations: A Review of 26 Cases in a University Hospital in Japan

Tohru Takata, MD, PhD[1,2]; Yoshinobu Yoshimura, MD, PhD[3]; Yumiko Obata, MD[2]; Atsushi Togawa, MD, PhD[2] and Yasushi Takamatsu, MD, PhD[2]; [1]Dep of Infection Control, Fukuoka University Hospital, Fukuoka, Japan, [2]Fukuoka University School of Medicine, Fukuoka, Japan, [3]Fukuoka University School of Medicine, Fukuouka, Japan

Session: 44. Clinical Mycology
Thursday, October 5, 2017: 12:30 PM

Background. Ocular candidiasis is a major complication of candidemia; however, many remains unknown for the incidence, risk factors, and outcome of eye involvement.

Methods. We retrospectively reviewed the medical records and obtained information related to fungal infection and its management, and visual outcome at Fukuoka University Hospital from 2000 to 2016.

Results. Of 143 patients with candidemia for whom an ophthalmology consult was requested, 26 had findings consistent with the diagnosis of ocular candidiasis. Patients with ocular candidiasis were mostly infected with *Candida albicans* (n = 20), followed by *C. glabrata* (n = 4), and *C. tropicalis* (n = 2). In contrast, only one patient infected with *C. parapsilosis* had ocular involvement although the number of the patients with *C. parapsilosis* candidemia was second the most among candidemia. No difference was seen for the β-D-glucan in patients with or without ocular candidiasis (128.6 vs. 106.1, P = 0.654). All of the isolates other than *C. glabrata* were susceptible to fluconazole. In all of 23 patients with existing central venous cathers, CVCs were removed after the diagnosis of candidemia. Four-week mortality rate in patients with ocular candidiasis was 16.7% (three of 18 patients) which was not significantly different from that in patients without ocular manifestations. All treated patients were confirmed for clearance of candidemia, received systemic antifungals, and improved for visual outcome or remained stable, and no patients complicated visual loss without surgical treatment. Therapy with micafungin or caspofungin followed by fluconazole (12 patients) was successful in all patients.

Conclusion. Ocular involvement occurred in 18% of patients with candidemia, and treatment with echinocandins followed by fluconazole was successful in most cases with follow-up.

Disclosures. **T. Takata**, Taisho Toyama Pharma: Speaker's Bureau, Speaker honorarium

188. Epidemiology, Risk Factors and Outcomes of Candida Empyema: A 5-Year Single-Centered Experience

Jonathan Williams, MD[1]; Odaliz Abreu Lanfranco, MD[2]; Juan Lemos-Ramirez, MD[1]; Pallavi Bhargava, MD[1]; George Alangaden, MD, FIDSA[3] and Mayur Ramesh, MD[2]; [1]Infectious Disease, Henry Ford Healthcare System, Detroit, Michigan, [2]Infectious Diseases, Henry Ford Hospital, Detroit, Michigan, [3]Wayne State University, Detroit, Michigan

Session: 44. Clinical Mycology
Thursday, October 5, 2017: 12:30 PM

Background. Candida empyema is a rare manifestation of invasive candidiasis and can occur as a result of candidemia or direct inoculation of the pleural space after thoracic or abdominal surgeries. The risk factors and outcomes of candida empyema are poorly defined.

Methods. We performed a retrospective descriptive analysis of all patients that had Candida species isolated from pleural fluid, from May 2012 to April 2017 at our institution.

Results. Sixty patients with Candida empyema were identified. Patient characteristics are shown in Table 1. The majority of patients 68% had contiguous surgery and 25% had recent solid organ transplantation most of these were lung/heart transplants. The majority isolates were non-*Candidia albicans* species (52%). Fifty-two patients (86.7%) received antifungals treatment for empyema: 72% received an azole and 13% received an echinoncandin. Fluconazole was the most frequent antifungal (63.3%). Mean duration of treatment was 4 weeks. Of these patients 78% underwent chest tube drainage (40% before diagnosis, 39% after diagnosis) and 22% required VATS/decortication. The overall 30-day mortality was 30%. Candidemia was noted in seven patients (11.7%). Thirty-day mortality was associated with sepsis OR 1.04–11.4, P = 0.049, history of diabetes P = 0.045 and sepsis at the time of candida isolation. A history of solid organ transplantation had a negative effect on mortality OR 0.01–1.07.

Conclusion. Candida empyema was associated with recent contiguous surgery in the majority of cases including lung/heart transplants. Candida empyema is associated with significant mortality despite antifungal treatment and drainage as was associated with sepsis syndrome and diabetes.

Variable	N = 60	*Candida albicans* 29 (48.3%)	Non-*Candida albicans* 31 (51.7)	P-value
Gender: male	40 (66.7)	20(69)	20(64.5)	0.78
Malignancy	16 (26.7)	7 (24.1)	9 (29)	0.77
Procedure within 1 year	41 (68.3	20 (69)	21(67.7)	0.99
Transplant	15(25)	6 (20.7)	9 (29)	0.56
Sepsis at time of infection	31(51.7)	14(48.3)	17(54.8)	0.79
Candidemia	7 (11.7)	2(6.9)	5(16.1)	0.42
30-day mortality	18(30)	10(34.5)	8(25.8)	0.57
Antifungal treatment	52(86.7)	24(82.8)	28(90.3)	0.46
Duration of treatment, weeks	4(2.5–6) 53 patients treated	3.88(2.4)	6.55(6.7)	0.009

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

189. Epidemiology and Outcomes of Hospitalizations with Invasive Aspergillosis in the United States, 2010–2013

Marya D. Zilberberg, MD, MPH[1]; Brian Nathanson, PhD[2]; Rachel Harrington, BA[3]; James Spalding, PharmD, MS, MBA[4] and Andrew F. Shorr, MD, MPH[5]; [1]Evimed Research Group, LLC, Goshen, Massachusetts, [2]OptiStatim, LLC, Longmeadow, Massachusetts, [3]Former Employee of Astellas Pharma Global Development, Inc, Northbrook, Illinois, [4]Astellas Pharma Global Development, Inc., Northbrook, Illinois, [5]Washington Hospital Center, Washington, DC

Session: 44. Clinical Mycology
Thursday, October 5, 2017: 12:30 PM

Background. Invasive aspergillosis (IA) complicates the care of up to 13% of patients with varying forms of immune compromise. The accompanying morbidity and mortality associated with IA remains high. We sought to describe the epidemiology and outcomes for all hospitalizations associated with IA in the United States.

Methods. We analyzed the National Inpatient Sample (NIS) from the Agency for Healthcare Research and Quality (AHRQ) for 2010–2013. We identified subjects with high-risk conditions for IA (stem cell or solid organ transplant, critical illness, major surgery, mild-to-moderate immune compromise, severe immune compromise, and other [human immunodeficiency virus, pneumonia, chronic obstructive pulmonary disease]). IA was identified via ICD-9-CM codes 117.3, 117.9, and 484.6. We compared characteristics and outcomes between those with (IA) and without IA (non-IA). We calculated the IA-associated excess mortality, length of stay (LOS) and costs using propensity-score (PS) matching.

Results. Of the 66,634,683 discharges who met the study inclusion criteria, 154,888 (0.2%) had a diagnosis of IA. Patients with IA were more likely to be male (50.9% IA vs. 46.7% non-IA, P < 0.001), and African American (15.3% IA vs. 12.5% non-IA, P < 0.001). The most common high-risk condition among those not classified as IA was major surgery (50.1%). In the IA group critical illness was noted most frequently (41.0%). The burden of both chronic (median [interquartile range, IQR] number of Elixhauser comorbidities 3 [1, 5] non-IA vs. 4 [3, 6] IA, P < 0.001) and acute (median [IQR] number of procedures during the hospitalization 2 [1, 3] non-IA vs. 3 [1, 6] IA, P < 0.001) illnesses was higher in the IA group than the non-IA. After PS-matching, mortality in IA (14.1%) was 37% higher than in non-IA (10.3%, P < 0.001), translating to an odds ratio = 1.43; 95% CI (1.36, 1.51). IA was associated with 6.0 (95% CI 5.7, 6.4) excess days in the hospital and excess $15,542 (95% CI $13,869, $17,215) in costs/hospitalization.

Conclusion. Although rare even among high-risk groups, IA is associated with high hospital mortality, excess duration of hospitalization, and costs. Given nearly 40,000 annual IA admissions in the United States, we estimate that the aggregate IA-attributable excess costs may reach $600 million annually.

Disclosures. **M. D. Zilberberg**, Astellas: Grant Investigator, Research support. **B. Nathanson**, EviMed, LLC: Consultant, Consulting fee. **R. Harrington**, Astellas Pharma Global Development, Inc.: Employee, Salary. **J. Spalding**, Astellas Pharma Global Development, Inc.: Employee, Salary. **A. F. Shorr**, Astellas: Consultant and Speaker's Bureau, Consulting fee, Research support and Speaker honorarium. Cidara: