Table 3. Characteristics of BSI in Covid Negative vs. COVID Positive patients				
	Overall	COVID Negative	COVID Positive	p-value
	n=185	n=117	n=68	
Primary	113 (61.1%)	89 (76.1%)	24(35.3%)	0.000
Secondary				
UTI	7 (3.8%)	5 (4.3%)	2 (2.9%)	
Skin	2 (1.1%)	2 (1.7%)	0	
Pneumonia	9 (4.9%)	3 (2.6%)	6 (8.8%)	
GU	3 (1.6%)	2 (1.7%)	1 (1.5%)	
Endocarditis	3 (1.6%)	3 (2.6%)	0	
CSF	2 (1.1%)	1 (0.9%)	1 (1.5%)	
CLABSI	46 (24.9%)	12 (10.3%)	34 (50 %)	0.000
Monomicrobial BSI	170 (91.9%)	110 (94%)	60 (88.2%)	0.165
Polymicrobial BSI	15 (8.1%)	7 (6%)	8 (11.8%)	0.165
Community Acquired BSI	106 (57.3%)	86 (73.5%)	20 (29.4%)	0.000
Hospital Acquired BSI	79 (42.7%)	31 (26.5%)	48 (70.6%)	0.000

Conclusion. Increased events of hospital acquired, secondary BSI (CLABSI) due to E*nterococcus* was observed in adult P compared to N. These patients were critically ill, developed BSI in the second week of hospitalization, had longer DOT prior to positive cultures and worse outcomes. Breakdown of infection control measures and inappropriate antimicrobial use during the surge could be contributory.

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

202. The Impact and Safety of Discontinuing Routine Surveillance Blood Culture Monitoring in Allogeneic Hematopoietic Cell Transplant Recipients

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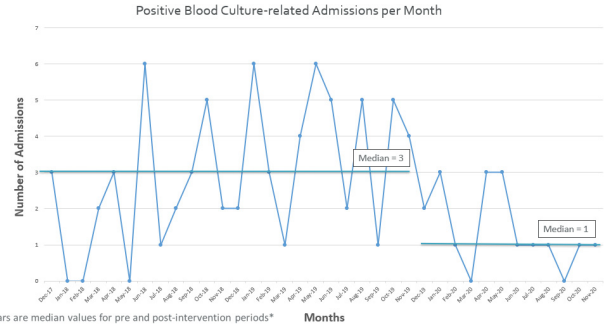
Session: P-10. Bacteremia

Background. Bloodstream infections (BSI) cause significant morbidity and mortality after hematopoietic cell transplant recipients (HCT). Surveillance blood cultures (SBC) are commonly used to decrease the risk of developing BSI but prior data suggest limited clinical utility. At our center, SBC monitoring was discontinued on 12/1/2019. This is a single center study evaluating the impact and safety of discontinuing routine SBC monitoring.

Methods. Retrospective review of allogeneic hematopoietic cell transplant recipients (HCTR) seen before (12/1/2017 – 11/30/2019) and after (12/1/2019 - 12/1/2020) discontinuation of SBC. We evaluated utility of SBC and the impact of discontinuation of SBC on admissions, mortality, and other variables.

Results. One hundred thirty-six and 133 HCTR were followed before and after discontinuation of SBC, respectively. Median (range) ages were 58 (22-73) and 56 (19-73); 60 (44%) and 59 (44%) were female, respectively. The most common cancer was acute myelogenous leukemia (71 (52%) and 61 (46%)); 87 (64%) and 77 (58%) had graft-versus-host disease respectively. Pre-intervention, 1946 SBCs were drawn; 81/1946 (4.2%) were positive. Post-intervention, 29 SBC were drawn; 1/29 (3.4%) were positive. Of the 82 positive SBCs, 63 (77%) were skin flora, and 9 (11%) were gram negative rods. No cultures grew *Staphylococcus aureus* or fungi. Fifty-one (63%) of the positive SBC resulted in an admission; median (range) length of stay (LOS) was 3 days (1-11). Following discontinuation of SBC, median monthly blood culture-related admissions decreased from 3 (0-6) to 1 (0-3) shown in Figure 1. In the pre-intervention period, there were 2 BSI-related deaths, and 0 following cessation of SBCs.

Figure 1. Monthly Hospital Admissions for Positive Outpatient Blood Cultures



Conclusion. SBCs were infrequently positive and often resulted in unnecessary antibiotic use, admission, and clinical interventions. After SBC monitoring was discontinued, there was a decrease in hospital admissions and health care utilization for positive blood cultures drawn in the outpatient setting. This intervention did not negatively impact clinical outcomes, including BSI-related mortality. Discontinuation of SBC appears to be safe and results in a reduction in healthcare utilization. Centers performing SBC should consider eliminating this practice.

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203. *Gardnerella vaginalis* Bacteremia in Male Patients: A Case Series and Review of the Literature

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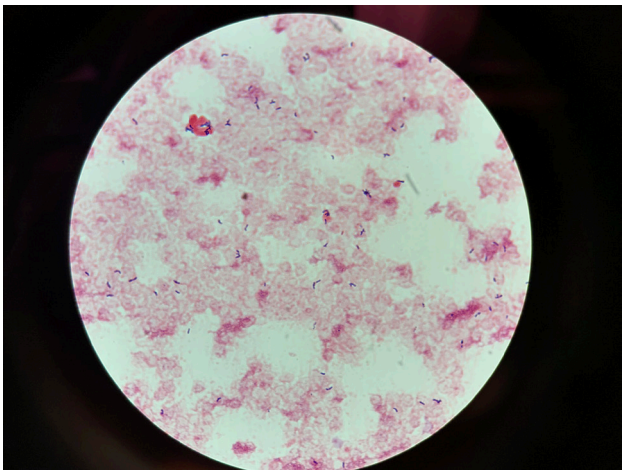
Session: P-10. Bacteremia

Background. **Introduction:** *Gardnerella vaginalis* is a colonizer of the female genitourinary tract and can cause serious morbidity as a pathogen. It is an uncommon cause of infection in men and bacteremia with this organism is rare. We describe two cases of *G. vaginalis* bacteremia in male patients. A literature search was performed for cases of *G. vaginalis* bacteremia in men. A total of 13 patients were identified and discussed.

Methods. **Case 1:** A 52-year-old man with diabetes and prior nephrolithiasis presented for dysuria, hematuria, and left sided flank pain. He was febrile and tachycardic with mild left costovertebral angle tenderness, leukocytosis and acute kidney injury. Urinalysis revealed pyuria. Computed tomography of the abdomen and pelvis showed pyelonephritis and a small calculus of the proximal left ureter. He was treated with ceftriaxone and then piperacillin-tazobactam. Aerobic culture of the urine yielded < 10,000 cfu/mL of mixed gram-positive flora. Blood cultures yielded *G. vaginalis* after 48 hours. He was treated with ciprofloxacin 500 mg orally twice daily for 7 total days and clinically recovered. **Case 2:** A 61-year-old man with alcohol use disorder and gout, presented with altered mental status. He had leukocytosis and acute kidney injury and was treated with vancomycin and cefepime with clinical improvement. Admission blood cultures demonstrated *G. vaginalis* in the anaerobic bottle of 1 of 2 cultures, reported 96 hours after collection. Urine culture was negative. The patient was treated with amoxicillin-clavulanate on discharge to complete a 14-day course with clinical resolution.

Results. see above

Gram stain of *G. vaginalis* on blood culture



Conclusion. **Discussion:** *G. vaginalis* is a facultative anaerobic gram-positive pleomorphic rod, which can be gram variable due to poor staining of the thin peptidoglycan cell wall. Isolation and identification are often delayed. Bacteremia in men is rare but nearly all have originated in the genitourinary tract. The most severe cases of *G. vaginalis* bacteremia implicate endocarditis, urethral stricture and an empyema as the sources. Collection of blood cultures and speciation are often delayed, ranging from 48 hours to 7 days. Selection and duration of treatment have ranged widely in previously reported cases, likely due to the lack of guidance regarding effective treatment.

Disclosures. **Andrew Chou, MD**, **bluebird bio** (Shareholder)

204. Clinical Outcomes with Ceftaroline Monotherapy versus Daptomycin-Ceftaroline Combination Therapy in the Treatment of Methicillin-Resistant *Staphylococcus aureus* Bacteremia

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Session: P-10. Bacteremia

Background. Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia is associated with poor outcomes and increased mortality. Daptomycin (DAP) and ceftaroline (CPT) in combination has been explored as a potential treatment option and showed improved outcomes compared to vancomycin/standard therapy. CPT

monotherapy has been evaluated as salvage therapy for MRSA bacteremia but, to our knowledge, not as a comparator to DAP-CPT combination therapy. The purpose of this study is to compare the clinical outcomes of DAP and CPT combination therapy to CPT monotherapy in the setting of MRSA bacteremia.

Methods. A retrospective chart review of adult patients (≥ 18 years of age) admitted to University Health from January 2017 to December 2020 with a diagnosis of MRSA bacteremia was performed. Patients received either CPT monotherapy or DAP-CPT combination therapy for a minimum of 48 hours during their course of therapy.

Results. Thirty-two patients met inclusion criteria and were evaluated. Primary source of infection was pulmonary in the CPT monotherapy group (n=7/24; 29.2%) and osteomyelitis in the DAP-CPT combination group (n= 4/8; 50.0%). Median duration of bacteremia was 8 days and 9 days in the CPT monotherapy and DAP-CPT combination group, respectively. Microbiological cure was achieved in 95.8% (n=23/24) of patients in the CPT monotherapy and 100% (n=8/8) of patients in the DAP-CPT combination group. Bacteremia relapse (30 day, p=0.62; 60 day, p=0.63), readmission rates (30 day, p=0.62; 60 day, p=0.63), and mortality rates (30 day, p=0.70; 90 day, p=0.85) were similar in both groups. There was no statistically significant difference in safety parameters, including incidence of acute kidney injury (p=1.00) and creatine kinase elevations (p=1.00). Bone marrow suppression after at least 72 hours of therapy, including anemia, leukopenia, and thrombocytopenia, was also not statistically significant between groups.

Conclusion. This study was unable to find a statistically significant difference in clinical outcomes between patients receiving CPT monotherapy or DAP-CPT combination therapy. A large prospective, randomized controlled trial to assess CPT monotherapy and DAP-CPT combination therapy for the treatment of persistent MRSA bacteremia is warranted.

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