

1920. Ocular Involvement in Candidemia Patients at an Urban Tertiary Care Center: Is Inpatient Ophthalmologic Consultation Essential?

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Background. Visual loss is a feared consequence of candidemia. The IDSA recommends dilated eye examination for all patients diagnosed with candidemia, irrespective of symptoms. Approximately 1% of patients with candidemia have ocular involvement. Given the low incidence, we posit that inpatient ophthalmologic consultation may not be required for every candidemic patient.

Methods. We retrospectively reviewed records of all patients with candidemia from June 2015 to March 2017. Age, gender, comorbidities, time to initiation of antifungal treatment, *Candida* species and choice of antifungal medication were recorded. We also obtained time to ophthalmology consultation and associated cost.

Results. A total of 120 patients with candidemia were identified (mean age 61; 62% male, 38% female). Seventy-nine percent had an indwelling venous catheter, 37% had DM, 24% were immunosuppressed, 16% had CKD, 14% were receiving TPN, and 15% were IVDU. Ninety-five percent of patients had received antibiotics in the previous 30 days. Twenty-six percent had undergone major surgery in the preceding 90 days. The majority of isolates were *Candida albicans* (46%). Average duration of candidemia was 4 days (range 1–18). Of the 120 patients, 73 (60%) underwent Ophthalmology evaluation. Two of those patients (2.7%) endorsed ocular symptoms, but only one had objective ocular involvement (retinitis without vitritis) which did not necessitate intravitreal therapy or surgery. The majority of our patients (68%) were treated with fluconazole. Initiation of antifungal therapy ranged from the day candidemia was diagnosed to 5 days later. Time to Ophthalmology consultation (from the time consult was requested) ranged from 1 to 9 days. Total cost for all ophthalmology consultations approximated \$22,000.

Conclusion. Ocular involvement was rare in our study. No change in short-term management was made based on ocular findings. However, there was substantial cost associated with inpatient ophthalmology consultation and probably with length of stay in patients awaiting eye examination. Hence, we suggest that inpatient eye evaluation may be reserved for patients with ocular symptoms (and those unable to verbalize complaints) as long as outpatient ophthalmology examination can be arranged.

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1921. Attributable Inpatient Costs of Hospital-Onset *Clostridium difficile* Infection: A Nationwide Case-Control Study in Japan

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Background. Hospital-onset *Clostridium difficile* infections (CDIs) have a considerable clinical and economic impact on both patients and payers. Quantifying the economic impact of CDIs can guide treatment strategies. However, previous studies have generally focused on acute care hospitals, and few have included cost estimates from nonacute care hospitals such as rehabilitation centres and long-term care facilities. The aim of this study was to quantify the hospital-onset CDI-attributable inpatient costs and length-of-stay durations in all healthcare institutions that provide inpatient care (including acute and nonacute care) in Japan.

Methods. Using national-level insurance claims data, we analyzed patients who had been hospitalized between April 2010 and December 2016. CDI case patients were identified and matched with non-CDI control patients using hospitalization year, treating hospital, age, sex, surgical procedure, comorbidities, and main diagnoses. Using multivariable regression analyses, we estimated the CDI-attributable inpatient costs and length-of-stay durations while adjusting for variations in factors such as age, sex, comorbidities, surgery, prescribed antibiotic, geographic region, and hospitalization year. We also analyzed the CDI-attributable inpatient costs and length-of-stay durations according to hospital type (acute care and rehabilitation/long-term care).

Results. The analysis was conducted using 3,768 matched pairs. Overall CDI-attributable inpatient costs and length-of-stay durations were US\$3,213 and 11.96 days, respectively. Rehabilitation/long-term care hospitals had substantially higher inpatient costs and longer hospitalizations than acute care hospitals.

Conclusion. This study quantified the hospital-onset CDI-attributable inpatient costs and hospitalizations in both acute and nonacute care hospitals. The inclusion of nonacute care hospitals provides a more accurate representation of the economic burden of CDIs.

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1922. The Challenges of Caring for People Who Inject Drugs: An Opportunity for an Infectious Diseases Service

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Background. The Royal London Hospital is a tertiary public hospital in the eastern region of London, UK—an ethnically diverse area with high levels of poverty and homelessness. Since its inception in 2015 the Infectious Diseases (ID) service has cared for 229 inpatients—10% were people who inject drugs (PWID). Such patients have complex problems including homelessness, domestic violence and psychiatric illness which impact their inpatient stay and discharge from the hospital.

Methods. To retrospectively evaluate the management and treatment of PWID managed by the ID team from April 2015 to June 2017 and identify strategies to improve care.

Patients were identified via electronic records. PWID not under the direct care of the ID team were excluded. Reason for admission, microbiological diagnosis, antibiotic choice, blood borne virus status, central venous access and other specialist input were noted.

Results. Twenty-two PWID were identified; 13 (59%) were male, median age was 39.5 years (IQR 32.5–46).

Table 1: Infectious Diagnoses of PWID

Complicated MSSA bacteremia	12
Complicated MRSA bacteremia	2
Complicated other bacteremia	2
Non bacteremic presentations	6
Pulmonary TB	3
Groin abscess	2
Vertebral osteomyelitis	1

Eighteen patients (82%) received antibiotics via a central line. There was one case of line-associated infection (*Candida glabrata*). Three patients (14%) left hospital against advice, eight attended follow-up after discharge. There were no deaths. The mean length of stay was 39 days. Thirteen patients were identified as homeless and eight of these (62%) were discharged to a home.

Conclusion. The majority of PWID managed by the ID team had complicated bacteremia requiring long courses of intravenous antibiotics. Despite concern regarding central access, line associated infection was rare. Significant proportions also had blood borne virus infection (86%) and over 50% had psychiatric illness and/or are homeless. Together these factors represent major obstacles to providing the considered “gold standard” care. These findings highlight the currently unmet need for an integrated multidisciplinary approach to the care of PWID.

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1923. OPAT or No-PAT? Evaluation of Outpatient Parenteral Antimicrobial Therapy (OPAT) Patients Receiving Daptomycin or Ertapenem for “Ease of Administration”

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Background. Outpatient parenteral antimicrobial therapy (OPAT) allows for long-course intravenous treatment of infections without lengthy hospital stays. Upon discharge, antimicrobial therapy may be broadened to ertapenem or daptomycin for “ease” of once-daily administration. Patients requiring subsequent readmission should be properly tailored to pre-OPAT regimens to minimize collateral damage and reduce cost. This study assessed the continuation of “ease of administration (EOA) regimens” upon hospital readmission during or immediately following OPAT.

Methods. This was a single-center, retrospective review of adult patients enrolled in OPAT and discharged between January 1, 2014 and September 30, 2017 on ertapenem or daptomycin for “EOA.” This was defined by the presence of the terms “convenience” or “EOA” in OPAT notes or by broadening of coverage to ertapenem or daptomycin upon OPAT enrollment despite adequate therapy with more narrow-spectrum agents. Patients receiving directed carbenem or daptomycin therapy prior to OPAT enrollment were excluded. The primary outcome was the percentage of patients readmitted during or within 90 days of their OPAT course and maintained on an “EOA regimen” of antibiotics. Secondary outcomes included inpatient therapy cost, rates of *Clostridium difficile* infection, and adverse drug reactions. Demographics and outcomes were summarized using descriptive statistics.

Results. Of the 188 patients receiving an OPAT “EOA regimen,” 71 were readmitted, representing 113 unique readmissions. Patients were mostly male (81%) with a median age of 57 years. “EOA regimens” were continued in 27% of hospital