in *Candida auris*. We analyzed all candidemia infections for signatures of transmission, including species, geographical, and temporal clusters. Here we present our preliminary data from December 2019 - May 2020.

Methods. This is a prospective and retrospective analytical observational study. Patients with candidemia were identified with the help of the Clinical Microbiology Lab at a University Medical Center. Data was collected on all identified patients by retrospective chart review. Data was described in terms of frequency distributions and percentages, and analyzed using SPSS. Isolates have been stored prospectively as glycerol stocks at -80 C for ongoing analyses.

Results. 37 patients were identified (Tables 1 and 2). Clusters of candidemia were seen in the months of January (*C. parapsilosis, 3 patients*), February (*C.glabrata*, 3 patients), March (*C.albicans*, 5 patients) and April (*C.glabrata*, 3 patients). 33/37 (89%) had a central line prior. Lines were removed in 73% (24/33) of these patients, the remaining patients were deceased before lines could be removed. Pancreatic pathology was seen in 15/37 (40.5%) patients (Table 3). 25/37 (67.5%) had an Ophthalmology consult.

Table 1. Patient demographics

Characteristic	Frequency	Percentage
Age distribution		
<1y	4	10.8
1-30 y	1	2.7
30-50 y	8	21.6
50-70 y	15	40.5
>70 y	9	24.3
Sex distribution		
Male	16	43.2
Female	20	54.0

Table 1. Patient demographics

Table 2. Epidemiology of candidemia

Species	Frequency	Percentage	Mortality (%) Overall 12/36 (33)	Amphotericin B Sensitivity	Fluconazole Sensitivity	Micafungin Sensitivity	Voriconazole Sensitivity
Candida albicans	12	32.4	5 (41.7)	No interpretation available	12 / 12 Sensitive	12 / 12 Sensitive	12 / 12 Sensitive
Candia glabrata	11	29.7	3 (27.2)	No interpretation available	**2 / 11 Intermediate, 2 / 11 Resistant**	**1 / 11 Resistant**	No interpretation available
Candida parapsilosis	7	18.9	2 (28.5)	No interpretation available	7 / 7 Sensitive	7 / 7 Sensitive	7 / 7 Sensitive
Candida tropicalis	2	5.4	0	No interpretation available	**1 / 2 Resistant**	Sensitive	Sensitive
Candida kefyr	1	2.7	1 (100%)	No interpretation available	No interpretation available	No interpretation available	No interpretation available
Candida krusei	1	2.7	1 (100%)	No interpretation available	**1 / 1 Resistant**	1 / 1 Sensitive	1 / 1 Sensitive
Candida dubliniensis	1	2.7	0	No interpretation available	No interpretation available	No interpretation available	No interpretation available
Candida orthopsilosis	1	2.7	0	No interpretation available	1 / 1 Sensitive	1 / 1 Sensitive	1 / 1 Sensitive
Candida utilis	1	2.7	0	No interpretation available	No interpretation available	No interpretation available	No interpretation available

Table 3. Pancreatic pathology in candidemia

Pancreatic pathology	Frequency	Percentage
Pancreatitis	5	13.5
Fatty atrophy	5	13.5
Pancreatic cancer	3	8.1
Pancreas divisum	3	8.1
Herniation of pancreas into mediastinum	2	5.4
Pancreatic cyst	1	2.7
Total	**15/37**	**40.5**

Table 3. Pancreatic pathology in candidemia

Conclusion. It is possible that the clusters identified shared equipment or other environmental factors that caused nosocomial transmission. We plan to use Whole Genome Sequencing to determine clonality among these isolates. The association of candidemia with pancreatic pathology was curious. It is to be evaluated whether this was simply a confounder or an actual risk factor that perhaps warrants consideration of prophylaxis. Rates of Ophthalmology consults to evaluate for endophthalmitis need to be improved in our setting. We hope that this study would prove valuable for infection control efforts and help us be better prepared to tackle emerging pathogens of this genus.

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1164. Epidemiology of Cryptococcal Infections in Non-HIV Patients: A 20-year Single Center Experience

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Session: P-52. Medical Mycology

Background. *Cryptococcus* has a worldwide distribution, *with C. neoformans* and *C. gattii* being two of the most common species causing disease. Despite advances in therapy, disseminated infection often results in significant morbidity and mortality.

Methods. We conducted a single center retrospective cohort study over a twenty-year period spanning from January 2000 through May 2020 to determine epidemiology and outcomes of non-HIV-associated cryptococcosis at Northwestern Memorial Hospital. Cases were identified by positive culture data or positive cryptococcal antigen in the serum or cerebrospinal fluid (CSF). Epidemiology of risk factors, morbidity, and mortality was evaluated.

Results. 81 cases were identified of which, 67 had *Cryptococcus spp* isolated from culture and the remaining patients diagnosed by cryptococcal antigen and/or histopathology. The cohort was primarily Caucasian (56.8%, n=46) and male gender (67.9%, n=55), with a median age of 59.5 (IQR: 52.75-66.25) years old. Common predisposing conditions were diabetes (37%, n=30), chronic kidney disease (34.6%, n=28), and liver disease (28.4%, n=23). Solid organ transplant recipients and use of immunosuppression accounted for, respectively, 32.1% (n=26) and 29.6% (n=24) of the cohort. Sites of infection include lung (65.4%. n=53), central nervous system (33.3%, n=27), blood (30.9%, n=25), peritoneum (6.2%, n=5), musculoskeletal (2.5%, n=2), and prostate (1.2%, n=1). Mean opening pressure on lumbar puncture was 25.3 mmHg (range: 9 -52 mmHg). In hospital mortality at time of diagnosis was 27.2% (n=22), and mortality at 12 months post diagnosis was 51.9% (n=42).

Conclusion. At our center, those with cryptococcosis commonly had risk factors such as immunosuppression either secondary to solid organ transplant or otherwise. Morbidity and mortality remain high.

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1165. Epidemiology, management and outcomes of fungal keratitis: A single center study from tertiary hospital in Thailand

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Background. Fungal keratitis is known as an important cause of sight threatening infection worldwide. Variation of clinical characteristics and treatment have been observed among different geographic regions. Currently, clinical data of fungal keratitis in South East Asia remain scarce.

Methods. A retrospective single study was conducted at King Chulalongkorn Memorial Hospital in Thailand. Medical records of patient with diagnosis of fungal keratitis between January 2016 and December 2018 were reviewed. Cases were identified using ICD-10 code. Data on demographics, clinical presentations, investigations and outcomes were collected. Mycological diagnosis was made in patients who had clinical presentation compatible with fungal keratitis and positive fungal detection in clinical specimen.

Results. During study period, fungal keratitis was diagnosed in 59 pts including 31 by mycological and 28 by clinical diagnosis. KOH preparation of corneal scraping was positive in 19 of 53 pts (35.8%). Culture from cornea, aqueous and vitreous yielded positive result in 18 of 53 (33.9%), 2 of 14 (14.3%), respectively. ITS sequence analysis was positive in 7 of 15 (46.7%) from cornea, 1 of 6 (16.7%) from aqueous and 2 of 2 (100%) from vitreous. Culture and molecular detection from clinical specimens provided additional mycological diagnosis in 8 and 5 cases with