Table 1: Characteristics of Patients with Pulmonary NTM Isolates

Characteristic	All Patients with pNTM Isolates	Patients Meeting pNTMi Criteria	Patients Not Meeting pNTMi Criteria	P-value
Number, N	225	109 (48.4)	116 (51.6)	
Age, median (IQR)	71 (62-79)	71 (64-79)	73 (61-80)	0.596
Gender, female	112 (49.7)	65 (60)	47 (41)	0.005
Race/ethnicity				0.504
White	154 (68.4)	74 (67.9)	80 (69)	
Black	21 (9.3)	7 (6.4)	14 (12.1)	
Asian	12 (5.3)	7 (6.4)	5 (4.3)	
Other/Unknown	38 (16.9)	21 (19.3)	17 (14.6)	
Unknown				
Body Mass Index (BMI), median (IQR)	24.3 (20.9-27.4)	22.6 (19.5-25.9)	25.1 (22.8-27.8)	0.001
Comorbidities				
Hypertension	148 (65.8)	67 (61.5)	81 (69.8)	0.207
Current or former smoker	129 (57.3)	65 (59.6)	64 (55.1)	0.504
Gastroesophageal reflux disease (GERD)	129 (57.3)	67 (61.5)	62 (53.4)	0.229
Cardiovascular disease	95 (42.2)	41 (37.6)	54 (46.6)	0.180
Chronic obstructive pulmonary disease (COPD)	84 (37.3)	43 (39.4)	41 (35.3)	0.582
Bronchiectasis	84 (37.3)	52 (47.7)	32 (27.6)	0.002
Diabetes mellitus	46 (20.4)	23 (21.1)	23 (19.8)	0.869
Solid organ malignancy	40 (17.8)	13 (11.9)	27 (23.3)	0.036
Autoimmune condition	39 (17.3)	21 (19.2)	18 (15.5)	0.485
Previous latent tuberculosis infection	22 (9.8)	10 (9.2)	12 (10.3)	0.825
Hematologic Malignancy	14 (6.2)	3 (2.8)	11 (9.5)	0.051
Mycobacterium isolates (total number)	813	166	647	
M. avium complex	123 (54.7)	82 (75.2)	41 (35.3)	0.001
M. simiae	41 (18.2)	11 (10.1)	30 (25.9)	0.003
M gordonae	21 (9.3)	2 (1.8)	19 (16.4)	0.001
M. fortuitum	15 (6.7)	3 (2.8)	12 (10.3)	0.031
M. abscessus	12 (5.3)	7 (6.4)	5 (4.3)	0.561
M. kansasaii	4 (1.8)	2 (1.8)	2 (1.7)	1
M. chelonae	2 (0.9)	0	2 (1.7)	0.499
Other Mycobacterium spp.	7 (3.1)	2 (1.8)	5 (4.3)	0.447

Data expressed as N (%) or Median (IQR)

Table 2: Characteristics of Patients Meeting pNTMi Diagnostic Criteria

Characteristic	Patients Offered Treatment	Patients Not Treated	P-value
Number, N	60 (55)	49 (45)	
Age, median (IQR)	70 (63-76)	73 (65-82)	0.049
Gender, female	33 (55)	32 (65)	0.328
Race/ethnicity			
White	40 (66.7)	34 (69.4)	
Black	6 (10)	1 (2.0)	
Asian	3 (5)	4 (8.2)	
Other/Unknown	11 (18.3)	10 (20.4)	
Body Mass Index (BMI), median (IQR)	23.7 (19.2-26.0)	22.1 (20.2-25.4)	0.672
Comorbidities			
Gastroesophageal reflux disease (GERD)	39 (65)	28 (57.1)	0.434
Current or former smoker	39 (65)	26 (53.1)	0.242
Hypertension	34 (56.7)	33 (67.3)	0.323
Chronic obstructive pulmonary disease (COPD)	31 (51.7)	12 (24.5)	0.006
Bronchiectasis	30 (50)	22 (44.9)	0.700
Cardiovascular disease	20 (33.3)	21 (42.9)	0.327
Autoimmune condition	14 (23.3)	7 (14.3)	0.329
Diabetes mellitus	14 (23.3)	9 (18.4)	0.639
Solid organ malignancy	8 (13.3)	5 (10.2)	0.769
Previous latent tuberculosis infection	5 (8.3)	5 (10.2)	0.751
Hematologic malignancy	3 (5.0)	0 (0)	0.251
Mycobacterium isolates (total number)			
M. avium complex	53 (88.3)	29 (59.2)	0.001
M. simiae	5 (8.3)	6 (12.2)	0.538
M gordonae	0 (0)	2 (4.1)	0.200
M. fortuitum	0 (0)	3 (6.1)	0.088
M. abscessus	1 (1.7)	6 (12.2)	0.044
M. kansasaii	1 (1.7)	1 (2.0)	1.000
M. chelonae	0 (0)	0 (0)	

Data expressed as N (%) or Median (IQR)

Conclusion. Approximately half of pNTM isolates were observed in patients who did not meet criteria for pNTMi diagnosis. Female patients, lower BMI, bronchiectasis, or MAC isolation were more likely to meet pNTMi criteria. Management of pNTMi remains a challenge, with younger patients with COPD and MAC more likely to receive treatment.

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1413. Effect of Automated Identification of Antimicrobial Stewardship Opportunities for Urinary Tract Infections

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Session: P-81. UTIs

Background. The treatment of asymptomatic bacteriuria (ASB) does not improve clinical outcomes in most patients and may be associated with an increased risk of adverse events such as *Clostridioides difficile* infection. A best practice alert (BPA) was created to identify patients with possible ASB for antimicrobial stewardship (AS) review. We aimed to determine whether automated identification of ASB improved the timing of stewardship intervention.

Methods. An electronic health record BPA message to inpatient AS pharmacists was activated on 01/19/2021. The BPA identified inpatients with a new antibiotic order with an associated genitourinary indication and a preceding urinalysis with 0 to 5 WBC/hpf. BPAs were reviewed by an AS pharmacist during weekdays and normal business hours. We retrospectively evaluated the impact of the BPA on time from order to stewardship intervention between a cohort of pre-BPA (01/2020 to 12/2020) and post-BPA (01/20/2021 to 04/10/2021) patients. Included patients met the BPA criteria and had an AS intervention within 7 days of the antibiotic order. We specified interventions that were UTI-related. The median time from antibiotic order entry to any AS intervention was compared pre- to post-BPA using the Mann Whitney U test. Rates of UTI-related interventions were compared with Fisher's Exact test.

Results. 327 antibiotic orders met BPA criteria and were analyzed: 245 and 82 in the pre- and post-BPA group, respectively. Groups had similar baseline characteristics (Table 1). A total of 33 (27 UTI-related) pre-BPA group and 24 (17 UTI-related) post-BPA group interventions were documented by the AS team. The median time to any intervention was 28 hours (IQR 18-64.5) in the pre-BPA group compared to 13.5 hours (IQR 3.5-28.75) in the post-BPA group (p = 0.03, Figure). The pre-BPA group had a lower rate of UTI-related interventions compared to the post-BPA group (11.0% vs 20.7%, p = .04).

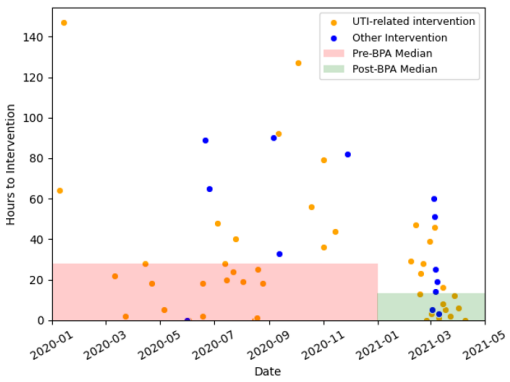
Table 1. Baseline Characteristics

Characteristics	Eligible Pre-BPA (n = 245)	Eligible Post-BPA (n = 82)
Median age, years (IQR)	64 (45-74)	58.5 (39-72)
Sex, male	101 (41.2)	32 (39)
Race		
Caucasian	141 (57.6)	49 (59.8)
African American	79 (32.2)	23 (28)
Other	25 (10.2)	10 (12.2)
eGFR within 48 hours	197 (80.4)	75 (91.5)
Median eGFR (IQR)	71 (45-93) mL/min/1.73m^2	75 (51-92.5) mL/min/1.73m^2
Pregnant	3 (1.2)	0 (0)
WBC within 48 hours	212 (86.5)	80 (97.6)
Median Serum WBC (IQR)	8.9 (6.9-13) x 10^9/L	9.2 (7.1-11.3) x 10^9/L
ANC < 1000	3 (1.2)	2 (5)
Urinary catheter	63 (25.7)	15 (18.3)
Urinalysis		
Positive nitrite	66 (26.9)	26 (31.7)
Urine culture in preceding 7 days	227 (92.6)	74 (90.2)
No growth	35 (15.4)	13 (17.6)
Mixed flora or < 10,000 cfu/mL organisms	73 (33)	16 (50)
Organism(s) identified	119 (52.4)	27 (36.5)
Urine culture organism	119 (48.6)	27 (32.9)
Enterobacterales	88 (73.9)	15 (55.6)
Enterococcus spp.	17 (14.3)	7 (25.9)
Pseudomonas aeruginosa	4 (3.4)	0 (0)
Other	10 (8.4)	5 (18.5)

[a]Data reported as n (%) or median (IQR)

[b]eGFR: estimated glomerular filtration rate; WBC: white blood cell; ANC: absolute neutrophil count

Figure: Time-to-Intervention among patients with UTI antibiotic order indication, absence of pyuria, and stewardship intervention



Conclusion. Automated identification of antibiotics targeting UTI with urinalysis showing absence of pyuria reduced the time to stewardship intervention and increased rate of UTI-specific interventions. The use of clinical decision support may aid in efficiency of AS review and syndrome-targeted AS impact.

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1414. Real-World Study of Healthcare Resource Use and Costs Associated with Inappropriate and Suboptimal Antibiotic Use Among Females with Uncomplicated Urinary Tract Infection in the United States

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Session: P-81. UTIs

Background. Urinary tract infections (UTIs) are the most common outpatient infection requiring medical care in the US; but, despite Infectious Diseases Society of America 2011 guidelines for treating uncomplicated UTI (uUTI), variation in prescribing practices still exists. Few studies have used real-world data (RWD) to evaluate uUTI-associated healthcare resource use (HRU) and costs. We examined HRU and direct costs associated with appropriate *and* optimal (AP&OP) and inappropriate *or* suboptimal (IA/SO) antibiotic (AB) prescribing in females with uUTI using US RWD.

Methods. This retrospective cohort study used RWD from IBM MarketScan (commercial/Medicare claims) to examine uUTI-related HRU and costs (inpatient, emergency room, outpatient, pharmacy) per index uUTI episode and during 1-year follow-up among females (age ≥ 12 years) diagnosed with uUTI from July 1, 2013–December 31, 2017 (index date). Patients had an oral AB prescription ± 5 days of the index date, and continuous health plan enrollment ≥ 6 months pre/1 year post-index date; those with complicated UTI were excluded. Patients were stratified by AB prescription as follows: AP&OP = guideline-compliant and correct duration; IA/SO = guideline non-compliant/incorrect duration or re-prescription/switch within 28 days.

Results. The study included 557,669 patients. In the commercial population (n=517,664, mean age 37.7 years), fewer patients were prescribed AP&OP (11.8%) than IA/SO (88.2%) ABs, a trend also seen in the Medicare population (n=40,005, mean age 74.5 years). In both populations, adjusted average numbers of uUTI-related ambulatory visits and pharmacy claims were lower for the AP&OP cohort than the IA/SO cohort during index episode and 1-year followup ($p < 0.0001$, Table 1). In the commercial population, total adjusted uUTI-related costs were $194 (AP&OP) versus $274 (IA/SO; $p < 0.0001$); in the Medicare population, total adjusted uUTI-related costs were $253 (AP&OP) versus $355 (IA/SO; $p < 0.0001$) (Table 2).

Table 1. uUTI-related HRU for commercial and Medicare populations calculated using the GLM model

Outcome variable‡	All patients (N=557,669)					
	Commercial population* (n=517,664)		p-value	Medicare population† (n=40,005)		p-value
	AP&OP prescription§ (n=60,132)	IA/SO prescription§ (n=300,660)		AP&OP prescription§ (n=2119)	IA/SO prescription§ (n=10,595)	
Index uUTI episode (per patient)						
Ambulatory visits, n (95% CI)	1.0 (1.0, 1.0)	1.1 (1.1, 1.1)	**< 0.0001¶**	0.9 (0.9, 1.0)	1.0 (1.0, 1.1)	**< 0.0001¶**
Pharmacy claims, n (95% CI)	1.0 (1.0, 1.0)	1.2 (1.2, 1.2)	**< 0.0001¶**	1.0 (1.0, 1.1)	1.2 (1.2 1.2)	**< 0.0001¶**
Proportion of patients with ambulatory visits, % (95% CI)	90.6 (90.4, 90.8)	90.5 (90.4, 90.6)	0.3897	83.5 (81.8, 85.0)	84.2 (83.4, 84.8)	0.4317
Proportion of patients with pharmacy claims, % (95% CI)	98.8 (98.7, 98.9)	98.8 (98.7, 98.8)	0.3425	97.3 (96.5, 97.9)	97.8 (97.5, 98.1)	0.0923
1-year follow-up period (per patient)						
Ambulatory visits, n (95% CI)	1.3 (1.3, 1.3)	1.4 (1.4, 1.4)	**< 0.0001¶**	1.3 (1.3, 1.4)	1.6 (1.6, 1.6)	**< 0.0001¶**
Pharmacy claims, n (95% CI)	1.3 (1.3, 1.3)	1.5 (1.5, 1.5)	**< 0.0001¶**	1.4 (1.3, 1.4)	1.7 (1.7, 1.7)	**< 0.0001¶**
Proportion of patients with ambulatory visits, % (95% CI)	92.3 (92.1, 92.5)	92.0 (91.9, 92.1)	**0.0313¶**	86.2 (84.7, 87.6)	87.3 (86.6, 87.9)	0.1858
Proportion of patients with pharmacy claims, % (95% CI)	98.9 (98.9, 99.0)	99.0 (98.9, 99.0)	0.5565	97.7 (97.0, 98.2)	98.3 (98.1, 98.6)	**0.0375¶**

*Mean (SD) age 37.7 (14.3) years; †Mean (SD) age 74.5 (7.9) years; ‡All values shown are adjusted averages; §The appropriateness of a prescription was defined as follows: AP, a guideline-compliant AB (first-line fosfomycin, nitrofurantoin, or TMP-SMX alone); OP, an AB prescribed for the correct duration (1 day for fosfomycin, 3 days for TMP-SMX, and 5 days for nitrofurantoin); IA, a guideline non-compliant AB (e.g., use of an AB that is not first-line treatment, or contemporaneous use of two first-line ABs); SO, where evidence of treatment failure exists (receipt of intravenous ABs/switch to a different oral AB within 28 days of index date, or primary UTI diagnosis within 28 days of initial diagnosis); ¶Statistically significant difference ($p < 0.05$).

AB, antibiotic; AP&OP, appropriate and optimal; CI, confidence interval; GLM, generalized linear model; HRU, healthcare resource use; IA/SO, inappropriate *or* suboptimal; SD, standard deviation; TMP-SMX, trimethoprim-sulfamethoxazole; UTI, urinary tract infection; uUTI, uncomplicated urinary tract infection

Table 2. uUTI-related costs for commercial and Medicare populations calculated using the GLM model

Outcome variables‡	Commercial population* (N=517,664)		p-value	Medicare population† (N=40,005)		p-value
	AP&OP prescription§ (n=60,132)	IA/SO prescription§ (n=300,660)		AP&OP prescription§ (n=2119)	IA/SO prescription§ (n=10,595)	
Index uUTI episode (per patient)						
Outpatient ambulatory costs, $ (95% CI)	132 (131, 133)	170 (169, 170)	**< 0.0001¶**	158 (150, 166)	186 (182, 190)	**< 0.0001¶**
Pharmacy costs, $ (95% CI)	11 (11, 11)	15 (15, 15)		13 (13, 14)	16 (16, 16)	
Total costs: inpatient + ER + ambulatory + pharmacy, $ (95% CI)	174 (172, 176)	257 (256, 259)		236 (222, 250)	315 (306, 323)	
Total costs: ≤ 99th %ile by cohort, $ (95% CI)	144 (143, 145)	209 (209, 210)		167 (158, 176)	218 (213, 224)	
1-year follow-up period (per patient)						
Outpatient ambulatory costs, $ (95% CI)	174 (173, 176)	221 (220, 222)	**< 0.0001¶**	223 (212, 236)	228 (281, 295)	**< 0.0001¶**
Pharmacy costs, $ (95% CI)	15 (14, 15)	19 (19, 19)		18 (17, 19)	23 (23, 24)	
Total costs: inpatient + ER + ambulatory + pharmacy, $ (95% CI)	232 (230, 234)	330 (328, 331)		372 (350, 396)	498 (484, 512)	
Total costs: ≤ 99th %ile by cohort, $ (95% CI)	194 (193, 196)	274 (272, 275)		253 (240, 268)	355 (346, 364)	

*Mean (SD) age 37.7 (14.3) years; †Mean (SD) age 74.5 (7.9) years; ‡All values shown are adjusted averages; §The appropriateness of a prescription was defined as follows: AP, a guideline-compliant AB (first-line fosfomycin, nitrofurantoin, or TMP-SMX alone); OP, an AB prescribed for the correct duration (1 day for fosfomycin, 3 days for TMP-SMX, and 5 days for nitrofurantoin); IA, a guideline non-compliant AB (e.g., use of an AB that is not first-line treatment, or contemporaneous use of two first-line ABs); SO, where evidence of treatment failure exists (receipt of intravenous ABs/switch to a different oral AB within 28 days of index date, or primary UTI diagnosis within 28 days of initial diagnosis); ¶Statistically significant difference ($p < 0.05$).

AB, antibiotic; AP&OP, appropriate and optimal; CI, confidence interval; ER, emergency room; GLM, generalized linear model; IA/SO, inappropriate *or* suboptimal; SD, standard deviation; TMP-SMX, trimethoprim-sulfamethoxazole; UTI, urinary tract infection; uUTI, uncomplicated urinary tract infection; %ile, percentile

Conclusion. Overall uUTI-related HRU and costs in the US were low during index episodes and follow-up. However, females with uUTI prescribed IA/SO ABs were more likely to incur higher HRU and costs than those prescribed AP&OP ABs, suggesting an unmet need for training to optimize uUTI prescribing per US guidelines.

Disclosures. **Madison T. Preib, MPH, STATinMED Research** (Employee, Former employee of STATinMED Research, which received funding from GlaxoSmithKline plc. to conduct this study) **Fanny S. Mitrani-Gold, MPH**, **GlaxoSmithKline plc.** (Employee, Shareholder) **Xiaoxi Sun, MA**, **STATinMED Research** (Employee, Employee of STATinMED Research, which received funding from GlaxoSmithKline plc. to conduct this study) **Christopher Adams, MPH**, **STATinMED Research** (Employee, Employee of STATinMED Research, which received funding from GlaxoSmithKline plc. to conduct this study) **Ashish V. Joshi, PhD**, **GlaxoSmithKline plc.** (Employee, Shareholder)

1415. Allergies to Antimicrobial Agents Among US Females with Uncomplicated Urinary Tract Infection

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Session: P-81. UTIs

Background. Uncomplicated urinary tract infections (uUTI) are generally treated empirically with antibiotics. However, antibiotic (AB) allergies limit the available oral treatment options for some patients. We assessed the proportion of self-reported AB allergies among US females with uUTI.

Methods. We performed a cross-sectional survey of US females ≥ 18 years of age with a self-reported urinary tract infection (UTI) in the 60 days prior to participation and a prescription of oral AB. Participants were further screened for evidence of a complicated urinary tract infection and, after exclusions, participants with a uUTI completed an online questionnaire about their most recent episode. Participants were from the Northeast (20%), Midwest (44%), South (20%), and West (16%) US. Descriptive self-reported allergy data were stratified into subgroups by whether the participant had recurrent UTI (defined as ≥ 2 uUTIs in the past 6 months or ≥ 3 uUTIs in past 12 months including index UTI), the number of different ABs given for the index episode (1, 2, ≥ 3), and whether the treatment was clinically appropriate according to Infectious Diseases Society of America uUTI guidelines.

Results. Overall, 375 female participants completed the questionnaire. The most commonly prescribed ABs for participants' most recent uUTI were trimethoprim-sulfamethoxazole (TMP-SMX; 38.7%), ciprofloxacin (22.7%), and nitrofurantoin (18.9%) (Table 1). Most participants received only 1 AB for their uUTI (62.7%) and the majority were classified as having a non-recurrent uUTI (56.5%). No AB allergies were reported for most participants (69.3%); overall, 24.0% reported 1 AB allergy and 6.7% reported ≥ 2. A higher proportion of participants reported ≥ 2 allergies in the recurrent uUTI, ≥ 3 AB, and multiple AB subgroups (Table 2). The most common allergy was to TMP-SMX (15.7%), followed by amoxicillin-clavulanate (8.3%) and ciprofloxacin (5.3%) (Table 2). Similar allergy trends were seen across subgroups, except higher rates of ciprofloxacin allergy were seen in participants given multiple ABs (Table 2).

Table 1. Antibiotics used to treat most recent uUTI

Antibiotic used to treat most recent uUTI (N=375)	n (%)
Trimethoprim-sulfamethoxazole	145 (38.7)
Ciprofloxacin	85 (22.7)
Nitrofurantoin	71 (18.9)
Cephalexin	56 (14.9)
Amoxicillin-clavulanate	35 (9.3)
Levofloxacin	11 (2.9)
Ofloxacin	10 (2.7)
Cefdinir	5 (1.3)
Fosfomycin	2 (0.5)
Cefaclor	0
Cefpodoxime-proxetil	0

uUTI, uncomplicated urinary tract infection.

Table 2 . Frequency of antibiotic allergies across cohort subgroups

	Total (N=375)	Recurrent uUTI		Number of AB for recent uUTI			Appropriateness of treatment		
		Yes (n=163, 43.5%)	No (n=212, 56.5%)	1 AB (n=235, 62.7%)	2 AB (n=88, 23.5%)	≥ 3 AB (n=52, 13.9%)	1 AB/1st line* (n=123, 32.8%)	1 AB/2nd line† (n=112, 29.9%)	Multiple AB‡ (n=140, 37.3%)
Antibiotic allergies, n (%)									
0	260 (69.3)	116 (71.2)	144 (67.9)	164 (69.8)	62 (70.5)	34 (65.4)	91 (74.0)	73 (65.2)	96 (68.6)
1	90 (24.0)	33 (20.2)	57 (26.9)	61 (26.0)	18 (20.5)	11 (21.2)	28 (22.8)	33 (29.5)	29 (20.7)
≥ 2	25 (6.7)	14 (8.6)	11 (5.2)	10 (4.3)	8 (9.1)	7 (13.5)	4 (3.3)	6 (5.4)	15 (10.7)
Trimethoprim-sulfamethoxazole	59 (15.7)	28 (17.2)	31 (14.6)	33 (14.0)	18 (20.5)	8 (15.4)	14 (11.4)	19 (17.0)	26 (18.6)
Amoxicillin-clavulanate	31 (8.3)	16 (9.8)	15 (7.1)	21 (8.9)	4 (4.5)	6 (11.5)	6 (4.9)	15 (13.4)	10 (7.1)
Ciprofloxacin	20 (5.3)	10 (6.1)	10 (4.7)	9 (3.8)	5 (5.7)	6 (11.5)	6 (4.9)	3 (2.7)	11 (7.9)
Cephalexin	14 (3.7)	6 (3.7)	8 (3.8)	9 (3.8)	2 (2.3)	3 (5.8)	5 (4.1)	4 (3.6)	5 (3.6)
Nitrofurantoin	7 (1.9)	1 (0.6)	6 (2.8)	6 (2.6)	0	1 (1.9)	2 (1.6)	4 (3.6)	1 (0.7)
Levofloxacin	5 (1.3)	3 (1.8)	2 (0.9)	2 (0.9)	1 (1.1)	2 (3.8)	0	2 (1.8)	3 (2.1)
Cefaclor	4 (1.1)	1 (0.6)	3 (1.4)	4 (1.7)	0	0	3 (2.4)	1 (0.9)	0
Ofloxacin	4 (1.1)	0	4 (1.9)	2 (0.9)	2 (2.3)	0	0	2 (1.8)	2 (1.4)
Cefdinir	3 (0.8)	3 (1.8)	0	1 (0.4)	2 (2.3)	0	0	1 (0.9)	2 (1.4)
Cefpodoxime-proxetil	2 (0.5)	0	2 (0.9)	1 (0.4)	1 (1.1)	0	0	1 (0.9)	1 (0.7)
Fosfomycin	0	0	0	0	0	0	0	0	0

*Defined as only one first-line oral AB used to treat last uUTI; †Defined as only one second-line oral AB used to treat last uUTI; ‡Defined as two or more different oral AB (any line) used to treat last uUTI.

AB, antibiotic; uUTI, uncomplicated urinary tract infection.

Conclusion. AB allergies were relatively frequent in this uUTI cohort and the most common allergy was to TMP-SMX, which was the most prescribed AB. Allergies to ABs reduce the available treatment options for uUTI in some patients.

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