Methods. A retrospective review of our centralized database was conducted of patient infections and therapy courses provided in POICs nationally that included complete data for 2017. All patients receiving IVAAs and drugs for CDI were included, along with dose, frequency, duration and method of administration. Descriptive measures were used to analyze data.

Results. A total of 12,930 infections were treated in 10,136 patients during 2017 among 77 POICs. Of those, 41% were treated directly from the community setting, avoiding hospitalization. Age distribution was <18 years <1%, 18–65 years 63% and >65 years 36%. Infections comprised 11 major diagnostic groups, with 47 subgroups. The most common diagnoses treated were bone and joint (37%), skin and skin structure (23%), genitourinary (14%) and bacteremia/septicemia (8%). 101 patients (1%) were treated for CDI. Geographical distribution occurred in the Midwest, Northeast, South, and West portion of the United States, where diagnoses were similar for all areas except the Northeast. This area had a significantly lower incidence of bone and joint infections ($P < 0.0001$) and a higher incidence of genitourinary infections ($P < 0.0001$). Overall utilization included 52 different agents, with 98.5% antimicrobials, 1% antifungals and 0.5% antivirals. Ceftriaxone was the most frequently used antimicrobial representing 16% of the total use, followed by vancomycin (14.5%), daptomycin (14.2%) and ertapenem (11%). The most prevalent infections and utilization of respective drug therapy is noted in the table.

Infection Incidence and Commonly Used Antimicrobials

Most Prevalent Diagnoses	Number of Therapy Courses Provided	Utilization (%)	Most Frequently Prescribed Drug (% Usage per Diagnosis)
Bone & Joint Infections	4854	37%	Vancomycin (20%), Daptomycin (19%), Ceftriaxone (16%), Cefazolin (14%), Cefepime (10%)
Skin, Skin Structure and Musculoskeletal Infections	3031	23%	Daptomycin (20%), Vancomycin (17%), Dalbavancin (15%), Ceftriaxone (12%)
Genitourinary Infections	1563	14%	Ertapenem (40%), Ceftriaxone (14%), Cefepime (14%)
Bacteremia/Septicemia	899	8%	Ceftriaxone (26%), Cefazolin (20%), Vancomycin (13%), Daptomycin (12%)
Intra-abdominal Infections	696	5%	Ertapenem (31%), Ceftriaxone (19%), Piperacillin/Tazobactam (17%)

Conclusion. This study provides an annual overview of outpatient infection incidence with the utilization of IVAAs and therapy for CDI. A wide range of moderate to severe infections were treated, often avoiding hospitalization. Treatment regimens were broad, utilizing a wide variety of drugs and enabling extensive patient management in the POIC setting.

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2368. Cellulitis in Adult Patients: A Large, Multicenter, Observational, Prospective Study of 606 Episodes, and Analysis of the Factors Related to the Response to Treatment

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Background. Cellulitis is frequent cause of admission of adult patients to medical wards. Increasing prevalence of multiresistant microorganisms, comorbidities, predisposing factors, and medical and surgical therapies might affect cellulitis response and recurrence rate.

Methods. Prospective and observational study of 606 adult patients with cellulitis admitted to the Internal Medicine wards of several Spanish hospitals. Comorbidities, microbiological, clinical, diagnostic, treatment (surgical and antibiotic) data were analyzed according to the cellulitis response. Good response implied cure. Poor response implied failure to cure or initial cure but relapse within 30 days of hospital discharge

Results. Mean age was 63.3 years and 51.8% were men. Poor responses were significantly associated with age, previous episodes of cellulitis, prior wounds and skin lesions, venous insufficiency, lymphedema, immunosuppression and lower limbs involvement No differences in ESR or CRP blood levels, leukocyte counts, pus or blood cultures positivity or microbiological or imaging aspects were observed in those with good or poor responses. Regarding antimicrobials, no differences in previous exposition before hospital admission, treatment with single or more than one antibiotic, antibiotic switch, days on antimicrobials or surgical treatment were observed regarding good or poor cellulitis response. Prior episodes of cellulitis ($P = 0.0001$), venous insufficiency ($P = 0.004$), immunosuppression ($P = 0.03$), and development of sepsis ($P = 0.05$) were associated with poor treatment responses, and non-surgical trauma ($P = 0.015$) with good responses, in the multivariate analysis.

Conclusion. Prior episodes of cellulitis, nonsurgical trauma, venous insufficiency, sepsis and immunosuppression were independently associated with treatment response to cellulitis, but not the causing microorganism, the number of antimicrobials administered or its duration.

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

2369. Clinical Experience With Telavancin for Treatment of Patients With Monomicrobial *S. aureus* Infections (Vancomycin MIC ≥1 µg/mL) From TOUR™

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Background. Telavancin (TLV) is a lipoglycopeptide antibacterial active against a wide range of Gram-positive pathogens, including methicillin-sensitive and -resistant *Staphylococcus aureus*. Infections due to *S. aureus* with elevated vancomycin (VAN) minimum inhibitory concentrations (MIC) are associated with worse clinical outcomes relative to those without elevated MIC.

Methods. A subset of patients with monomicrobial infections due to *S. aureus* and VAN MIC ≥1 µg/mL were characterized from the Telavancin Observational Use Registry (TOUR™), a multicenter chart review to characterize infection types, pathogens, and outcomes of patients treated with TLV in clinical practice. Patient demographics, pathogens, outcomes, and adverse events (AEs) were analyzed. Clinical outcomes were determined by investigator assessment.

Results. Of 159 patients with monomicrobial *S. aureus* and VAN MIC ≥1 µg/mL, 25.8% were aged ≥65 years (median 54.0, range 40–65 years), 60.4% were male, and 84.9% were White. At enrollment, complicated skin and skin structure infections (45.9%), bacteremia (20.1%), and osteomyelitis (15.7%), were the most common infection types. Median TLV daily dose was 750 mg (range 285–2000 mg) or 8.5 mg/kg (range 3.5–15.7 mg/kg) and treatment duration was 8 days (range 1–185 days). TLV was used as second-line or later therapy in 77.4% patients, 73.6% failed prior therapy, and 44.0% previously received VAN. A total of 104 (65.4%) patients had VAN MIC = 1 µg/mL; 4 (2.5%) had MIC = 1.5 µg/mL, and 51 (32.1%) had MIC = 2 µg/mL. At end of treatment, 87 (77.0%) patients with available assessment had a positive clinical response, 17 (15.0%) had an indeterminate response, and 9 (8.0%) failed treatment. Assessment data from 10 (8.1%) patients were missing or undocumented, and indeterminate for 17 (13.8%) patients. AEs were reported in 17 (10.7%) patients; 9 (5.7%) reported a serious AE, and 12 (7.5%) had AEs leading to TLV discontinuation. A total of 7 (4.4%) renal AEs were reported; 5 (3.8%) patients discontinued due to renal AEs.

Conclusion. In a real-world setting, where the majority of patients had been on prior antibiotics, once-daily TLV was effective in treating a variety of infections due to *S. aureus* with decreased susceptibility to VAN.

Disclosures. **M. Jacobs**, Theravance Biopharma, US: Investigator, Fee for data collection and submission. **C. Nwaigwe**, Theravance Biopharma, US: Speaker's Bureau, Speaker honorarium. **C. Clay**, Theravance Biopharma, US: Employee and Shareholder, Salary. **C. Barnes**, Theravance Biopharma, US: Employee and Shareholder, Salary. **B. Castaneda-Ruiz**, Theravance Biopharma, US: Employee and Shareholder, Salary.

2370. Dalbavancin Use in Emergency Department and Observation Unit to Prevent Inpatient Admission for Acute Bacterial Skin and Skin Structure Infection (ABSSI)

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Background. ABSSSIs are a common cause of hospitalization. Dalbavancin (DBV) is a lipoglycopeptide antibiotic approved as a single 1,500 mg intravenous (IV) dose for the treatment of patients with ABSSSI. DBV offers a unique opportunity for cost avoidance by shifting more ABSSI treatment to the outpatient setting. In late 2016, DBV was added to Northwest Hospital formulary with a restriction to patients with ABSSSI in the emergency department (ED) and observation unit who would otherwise be admitted for IV antibiotic therapy. The objective of this study was to assess the resource-effectiveness of DBV infusion as an alternative to inpatient admission for ABSSI management.

Methods. We performed a retrospective review of patients that received DBV in calendar-year (CY) 2017. The primary outcome was avoidance of inpatient admission and 30-day return to any ED as captured by the Chesapeake Regional Information System. Secondary outcomes were reported adverse drug reactions (ADRs) and inpatient resource utilization for the diagnosis-related group of cellulitis without major complication or comorbidity (MS-DRG 603) in CY 2017 vs. CY 2016.

Results. A total of 32 patients received DBV in 2017 in the ED or observation setting. Of these, one was admitted the same day and seven had ED returns within 30 days. Of these seven patients, only two had ED returns related to ongoing cellulitis/possible DBV failure. One of these two patients received a second dose of DBV and was sent home while the other required inpatient admission. There were no DBV