(Other Financial or Material Support, Personal fees)**Grupo Biotoscana** (Other Financial or Material Support, Personal fees)**Janssen Pharmaceuticals** (Grant/Research Support)**Matinas** (Other Financial or Material Support, Personal fees)-**Medicines Company** (Grant/Research Support)**MedPace** (Grant/Research Support)**MedPace** (Other Financial or Material Support, Personal fees)**Melinta Therapeutics** (Grant/Research Support)**Menarini Ricerche** (Other Financial or Material Support, Personal fees)**Merck/MSD** (Other Financial or Material Support, Personal fees)**Merck/MSD** (Grant/Research Support)**Mylan Pharmaceuticals** (Consultant)**Nabriva Therapeutics** (Other Financial or Material Support, Personal fees)**Octapharma** (Other Financial or Material Support, Personal fees)**Paratek Pharmaceuticals** (Other Financial or Material Support, Personal fees)**Pfizer** (Other Financial or Material Support, Personal fees)**Pfizer** (Grant/Research Support)**PSI** (Other Financial or Material Support, Personal fees)**Rempex** (Other Financial or Material Support, Personal fees)**Roche Diagnostics** (Other Financial or Material Support, Personal fees)**Scynexis** (Other Financial or Material Support, Personal fees)**Scynexis** (Grant/Research Support)**Seres Therapeutics** (Other Financial or Material Support, Personal fees)**Tetraphase** (Other Financial or Material Support, Personal fees) **Philipp Koehler, MD**, **Akademie für Infektionsmedizin e.V.,** (Other Financial or Material Support, Personal fees)**Astellas Pharma GmbH** (Other Financial or Material Support, Personal fees)**Cologne Excellence Cluster on Cellular Stress Responses in Aging-Associated Diseases, University of Cologne, Cologne, Germany** (Other Financial or Material Support, Other)**Gilead Sciences GmbH** (Other Financial or Material Support, Personal fees)**GPR Academy Ruesselsheim** (Speaker's Bureau)**Miltenyi Biotec GmbH** (Other Financial or Material Support, Non-financial support)**MSD Sharp & Dohme GmbH** (Other Financial or Material Support, Personal fees)**Noxxon N.V.** (Speaker's Bureau)**University Hospital, LMU Munich** (Other Financial or Material Support, Personal fees) **Katrien Lagrou, n/a**, **FUJIFILM WAKO** (Speaker's Bureau)**Gilead** (Consultant, Speaker's Bureau)**MSD** (Consultant, Speaker's Bureau, Other Financial or Material Support, travel grant)**Pfizer** (Speaker's Bureau, travel grant)**SMB Laboratoires Brussels** (Consultant) **Zdenek Racil, n/a**, **Astellas** (Grant/Research Support, Speaker's Bureau, travel grant) **Blandine Rammaert, n/a**, **Gilead** (Speaker's Bureau, Other Financial or Material Support, travel grant)**Merck/MSD** (Speaker's Bureau)**Pfizer** (Other Financial or Material Support, travel grant) **Nikolay Klimko, n/a**, **Astellas** (Speaker's Bureau)**Gilead** (Speaker's Bureau)**Merck/MSD** (Speaker's Bureau)**Pfizer** (Speaker's Bureau) **Sung-Yeon Cho, MD**, **Gilead** (Grant/Research Support, Speaker's Bureau)**Merck Sharp & Dohme** (Grant/Research Support, Speaker's Bureau)**Pfizer** (Grant/Research Support, Speaker's Bureau)

1599. Clinical Outcomes for Patients Treated with Fluoroquinolones for Bacteremia Caused by Enterobacteriaceae Reclassified as Not Susceptible by Updated CLSI Breakpoints

Zachary Fleischner, MD[1]; Wendy Szymczak, PhD[2]; Gregory Weston, MD MSCR[3]; [1]Montefiore Medical Center, Bronx, New York; [2]Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, NY; [3]Montefiore Medical Center and Albert Einstein College of Medicine, Bronx, New York

Session: P-71. Treatment of Antimicrobial Resistant Infections

Background. Antibiotic resistance remains a pressing public health challenge. Antibiotic susceptibility testing is crucial to identify resistance and predict which antibiotics are most likely to be effective. In vitro minimum inhibitory concentrations (MICs) are interpreted using MIC breakpoints set for the United States by The Clinical and Laboratory Standards Institute (CLSI). In 2019 CLSI updated fluroquinolone (FQ) breakpoints for Enterobacteriaceae. Previously any isolate with an MIC ≤ 1 μg/mL of ciprofloxacin would be considered susceptible but based largely on pharmacokinetic/pharmacodynamic simulations the susceptibility breakpoint was revised to ≤ 0.25 μg/mL. However, the clinical relevance of this decision remains unclear.

Methods. All cases of Enterobacteriaceae bacteremia with isolates previously considered susceptible but reclassified as resistant (MIC = 1 μg/mL) in adults treated with FQs between 08/01/2018 and 07/31/2019 were identified. Demographics, clinical characteristics and outcomes were compared with an equal number of randomly selected isolates with an automated MIC reported as ≤ 0.5 μg/mL. Available stored isolates with a reported MIC of ≤ 0.5 μg/mL had manual E-testing performed to identify a more precise MIC.

Results. 29 cases with an MIC = 1 μg/mL were compared with 29 controls with a MIC of ≤ 0.5. Only 3 cases and 1 control received FQs as empiric therapy, the remaining patients in each group were transitioned to FQ after a median of 4 days of other antibiotics. No significant difference was found for predetermined outcomes including 30 day mortality, escalation after starting FQ, length of hospital stay, and readmission in 30 days (see Table). No primary outcome was thought to be related to antibiotic failure. E-testing found no isolates with an MIC = 0.5 μg/mL.

Table 1

	MIC = 1 (n = 29)	MIC ≤ 0.5 (n = 29)
30 day mortality	0	1 (3.4%)
Non-sterilization (w/FQ)	0	0
Escalation after starting FQ	1 (3.4%)	0
LOS	6.5 days	6.2 days
Readmission (30d)	6 (21%)	7 (24%)

Conclusion. Patients with Enterobacteriaceae bacteremia treated with FQs for isolates reclassified as resistant had similar outcomes to those with lower MICs. While FQs are generally not recommended as first line empiric antibiotics, FQs may still be safe to use as stepdown therapy for isolates with a ciprofloxacin MIC = 1 μg/mL, particularly if the only alternative may be IV antibiotics. A larger study is needed to confirm this.

Disclosures. Gregory Weston, MD MSCR, Allergan (Grant/Research Support)

1600. Closing the gap on moxifloxacin breakpoints for *Stenotrophomonas maltophilia*

Tyler J. Stone, PharmD[1]; Kate Summers, PharmD[1]; John Williamson, PharmD[2]; Elizabeth Palavecino, MD[2]; Elizabeth Palavecino, MD[2]; [1]Wake Forest Baptist Health, Winston-Salem, North Carolina; [2]Wake Forest Baptist Health System, Winston Salem, NC

Session: P-71. Treatment of Antimicrobial Resistant Infections

Background. Moxifloxacin (MOX) has *in vitro* activity against Enterobacterales and *Stenotrophomonas maltophilia* (SM). Although MOX commonly displays lower minimum inhibitory concentration ($MIC_{50/90}$ values against SM when compared to levofloxacin, there are currently no established MOX breakpoints for treatment of SM. The Clinical and Laboratory Standards Institute (CLSI) has established interpretive categories and MIC breakpoints for levofloxacin (S ≤2μg/ml) against SM. The US Food and Drug Administration and European Committee on Antimicrobial Susceptibility Testing provide MOX breakpoints for Enterobacterales with susceptible MICs represented at ≤ 2 μg/mL and ≤ 0.25 μg/mL, respectively. The purpose of this study was to evaluate MOX MIC distribution against SM strains recovered from clinical specimens.

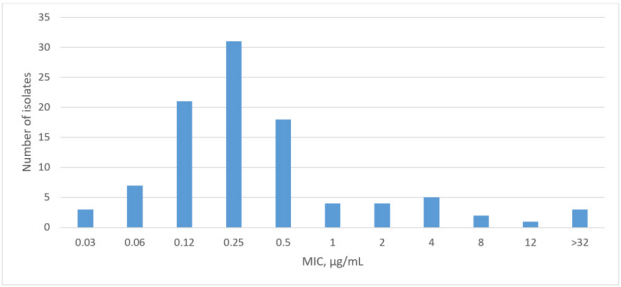
Methods. Clinical samples from patients with suspected infection during calendar year 2018 and 2019 were processed in the microbiology lab of Wake Forest Baptist Medical Center. After incubation, SM colonies were identified by MALDI-TOF system. MOX susceptibility testing was performed for these clinical isolates by gradient diffusion strip methodologies. Results were displayed as MIC (μg/mL) without interpretation. $MIC_{50/90}$ and susceptibility rates at potential breakpoints were calculated.

Results. A total of 211 isolates were tested, 112 from 2018 and 99 from 2019. MOX MIC_{50} and MIC_{90} for all isolates was 0.25 μg/mL and 2 μg/mL, respectively. The range of MIC distribution was ≤ 0.006 μg/mL to ≥ 64 μg/mL. Percent susceptibilities at incremental MICs, including established MOX breakpoints against Enterobacterales and established levofloxacin breakpoints against SM, are represented in Table 1. MIC distribution was plotted in Figure 1.

Table 1. Susceptibility rates of S. maltophilia to moxifloxacin at theoretical breakpoints

Breakpoint (μg/mL)	Percent Susceptible		
	All (n=211)	2018 (n=112)	2019 (n=99)
≤ 0.25	69%	75%	63%
≤ 1	88%	90%	85%
≤ 2	93%	97%	89%

Figure 1. Moxifloxacin MIC Distribution against All S. maltophilia Isolates



Conclusion: With no established breakpoint, these data represent one of the largest samples of MOX MICs against SM in the United States. Using the CLSI breakpoint for levofloxacin in SM (MIC of ≤2ug/ml) the overall susceptibility rate is 93%. This finding highlights the importance of performing susceptibility testing to this agent by the microbiology laboratory and the critical need for MOX breakpoints in SM.

Disclosures. **Tyler J. Stone, PharmD**, **Paratek** (Research Grant or Support) **John Williamson, PharmD**, **Paratek** (Research Grant or Support) **Elizabeth Palavecino, MD**, **Paratek** (Grant/Research Support)**Paratek** (Grant/Research Support)

1601. Combination Therapy versus Monotherapy for Carbapenem-resistant Organisms: Is More Really Better?

Laila Najia, PharmD[1]; Amy Carr, PharmD[1]; Jose Alexander, MD[1]; Sarah B. Minor, PharmD, BCPS-AQ ID[2]; [1]AdventHealth Orlando, Orlando, Florida; [2]AdventHealth, Winter Springs, FL

Session: P-71. Treatment of Antimicrobial Resistant Infections

Background. Carbapenem-resistant organisms (CROs) represent an urgent public health threat and associated with mortality rates up to 60%. Pharmacotherapy for these infections remain challenging and historically included multiple agents. Meropenem/vaborbactam and ceftazidime/avibactam are options to treat CRO infections as monotherapy; however, combination therapy is still frequently utilized. Data