595. Letermovir (LTV) for Secondary Cytomegalovirus (CMV) Prevention in High Risk Hematopoietic Cell Transplant (HCT) Recipients: Interim Results of a Single Center, Open Label Study

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Session: P-26. Care Strategies for Transplant Patients

Background. Letermovir (LTV) is effective for prevention (ppx) of primary clinically significant CMV infection (csCMVi) in the first 100 days after hematopoietic cell transplant (HCT). Data on LTV for secondary ppx is limited. We report on the efficacy and safety of LTV administered for 14 weeks as secondary CMV ppx.

Methods. Patients (pts) enrolled in an open label study of LTV (ClinicalTrials.gov identifier: NCT04017962) from August 2019 through February 2021 were analyzed. Key eligibility criteria were: CMV high risk (receipt of mismatched and/or T-cell depleted HCT and/or graft versus host disease (GVHD) requiring systemic immunosuppressants) AND prior csCMVi with either undetectable CMV (≤ 136 IU/mL) or ≥ 2 consecutive values < 300 IU/mL at enrollment. Pts with breakthrough csCMVi on LTV or history of LTV resistance were excluded. LTV was administered for 14 weeks or csCMVi whichever occurred first. The study duration was 24 weeks. CMV was monitored per standards of care. The primary endpoint was csCMVi by week 14. Secondary endpoints were csCMVi by week 24, LTV resistance, CMV end-organ disease (EOD) and adverse events (AE) at least possibly related to LTV.

Results. Of 20 pts analyzed, the median age was 58 years (interquartile range [IQR] 46-63); 17 (85%) pts were CMV seropositive, 7 (35%) received mismatched HCT (haploidentical 3, cord blood 3; mismatched unrelated 1), 9 (45%) received CD34 selected allograft and 9 (45%) had GVHD at enrollment. Fourteen (70%) pts had received prior LTV. The median time from HCT to enrollment was 156 (IQR 37-244) and 55 (IQR 40-69) days for pts with and without prior LTV, respectively (P=0.16). CMV at enrollment was < 136IU/mL for 8 (40%) pts. By week 14, 4 (20%) pts developed csCMVi at median 48 days (range 40-66). Resistance testing performed in 3 of the 4 pts, identified LTV resistance mutations in 2 pts. There were no AEs related to LTV, and none developed EOD. Two pts developed csCMVi in the follow up phase. Three pts died during follow up (due to relapse, treatment related toxicity and GVHD), and four pts are in follow up.

Conclusion. LTV secondary prophylaxis was safe and prevented recurrent csCMVi in 80% of high risk patients, including patients with prior LTV exposure. Our data supports the utility of LTV for secondary CMV prevention following HCT.

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596. The ID Physician Is Out: Are Remote ID E-Consults an Effective Substitute?

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Session: P-27. Clinical Practice Issues

Background. Telemedicine (TM) can provide specialty ID care for remote and underserved areas; however, the need for dedicated audio-visual equipment, secure and stable internet connectivity, and local staff to assist with the consultation has limited wider implementation of synchronous TM. ID e-consults (ID electronic consultations or asynchronous™) are an alternative but data are limited on their effectiveness, especially patient outcomes.

Methods. In the setting of the COVID-19 pandemic and ID physician outage, we were asked to perform ID e-consults at a 380-bed tertiary care hospital located in Blair County, PA. We performed retrospective chart reviews of 121 patients initially evaluated by ID e-consults between April 2020 and July 2020. Follow-up visits were also conducted via e-consults with or without direct phone calls with the patient. Key patient outcomes assessed were length of stay (LOS), disposition after hospitalization, 30-day mortality from initial ID e-consult and 30-day readmission post-discharge.

Results. The majority of patients were white males and non-ICU (Table 1). The most common ID diagnosis was bacteremia (27.3%, 33/121), followed by skin and soft tissue infections (15.7%, 19/121) and bone/joint infections (14.9%, 18/121) (Figure 1). Table 2 shows patient outcomes. Average total LOS was 11 days and 7 days post-initial ID e-consult. 48.7% (59/121) of patients were discharged home and 37.2% (45/121) to a post-acute rehabilitation facility. 2.5% (3/121) of patients required transfer to a higher level of care facility; none of which were to obtain in-person ID care. The index mortality rate was 3.3% (4/121), which appears to be lower than published data for in-person ID care. The 30-day mortality rate was 4.1% (5/121), which is also comparable to previously reported for ID e-consults. 25.6% (31/121) of patients required readmission within 30 days but only 14.0% (17/121) were related to the initial infection.

Table 1. Demographics

Age, mean (SD), y	61.2 (16.7)
Gender, No. (%)	
Female	50 (41.3)
Male	71 (58.7)
Race, No. (%)	
White	115 (95.0)
Other	6 (5.0)
BMI, mean (SD)	31.5 (8.6)
Immunocompromised State, No. (%)	21 (17.4)
Immunosuppressive Agents*	5 (4.1)
Solid Tumor	11 (9.1)
Hematologic Malignancy	5 (4.1)
Charlson Comorbidity Index Score, mean (SD)	4.8 (3.0)
Hospitalization during previous 6 mo, No. (%)	
Yes	57 (47.1)
No	64 (52.9)
ICU status at the time of e-consult, No. (%)	
Yes	13 (10.7)
No	108 (89.3)

*Immunosuppressive agents include: Apremilast, Dasatinib, Etanercept, Remicade, Rituximab, and Prednisone >10 mg/day

Figure 1. Variety of ID Diagnoses made by e-consults

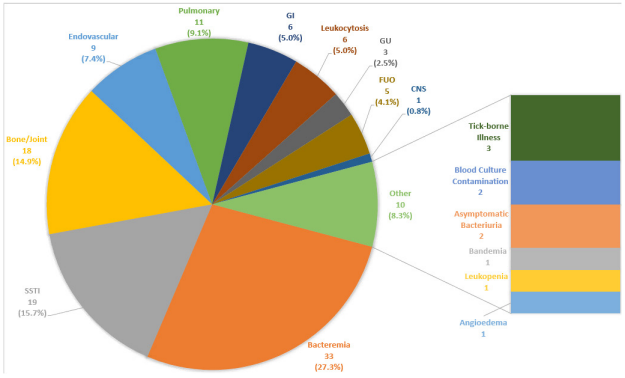

Table 2. Outcomes

Length of stay, mean (SD), d	
Total	11 (9)
Post-e-consult	7 (8)
Disposition, No. (%)	
Home	59 (48.7)
Post-acute rehabilitation facility	45 (37.2)
Left against medical advice	7 (5.8)
Hospice	3 (2.5)
Hospital transfer	3 (2.5)
Index stay mortality	4 (3.3)
Death within 30 d of ID e-consult, No. (%)	5 (4.1)
Readmission within 30 d post-discharge, No. (%)	31 (25.6)
Readmission within 30 d related to initial infection, No. (%)	17 (14.0)

*Immunosuppressive agents include: Apremilast, Dasatinib, Etanercept, Remicade, Rituximab, and Prednisone >10 mg/day