Table 1. Characteristics of patients

Patient characteristics	Number	%
Total screened	2365	
Positive Strongyloides	116	4.9
Age group		
60–70 years	41	36
50–59 years	23	20
40–49 years	22	19
<40	27	24
Sex		
Male	90	80
Female	23	20
Ethnicity		
White	81	72
Hispanic	18	16
African American	14	12
Occupation with soil or water contact	21	19
Total SOT patients	38	87
Treated before SOT	33	97
Ivermectin	32	3
Albendazole	1	
Travel or birth outside United States	35	31
Puerto Rico	12	34
Caribbean and South America	10	29
Middle East	3	8
Africa	2	6
Europe and Australia	3	8
Asia	5	14
Eosinophilia >5%	17	15

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

134. Investigation of a Contaminated, Nationally Distributed, Organ Transplant Preservation Solution — United States, 2016–2017

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Thursday, October 5, 2017: 10:30 AM

Background. In December 2016, bacterial contamination of an organ preservation solution (OPS) was reported by Transplant Center A in Iowa. Annually, >20,000 abdominal organs are transplanted in the United States; OPS is used for organ storage. We investigated the scope of OPS contamination and its association with adverse events in patients.

Methods. We assessed infection control practices related to OPS at Transplant Centers A and B in Iowa and the local organ procurement organization (OPO). We issued national notifications about OPS contamination and requested transplant centers to report product-related concerns or potential patient harm. Among transplant recipients at Center A, we compared adverse events (fever, bacteremia, surgical site infection, peritonitis, or pyelonephritis within 14 days of transplantation) during October–December 2015 with October–December 2016, the presumed window of exposure to contaminated OPS. Isolates from OPS were characterized.

Results. No infection control deficiencies were identified at Transplant Centers A, B, or the OPO. In January 2017, contaminated OPS from the same manufacturer was reported by Transplant Center C in Texas. Nationally, there were no reports of patient harm definitively linked to OPS. Post-transplant adverse events at Center A did not increase between fourth quarter 2015 (5/12 [42%]) and 2016 (2/15 [13%]). Organisms recovered from OPS included *Pantoea agglomerans* and *Enterococcus gallinarum* (Center A) and *Pseudomonas koreensis* (Center C). Five *Pantoea* isolates from ≥3 opened OPS bags were indistinguishable by pulsed-field gel electrophoresis. The OPS distributor issued recalls and suspended production. The US Food and Drug Administration identified deficiencies in current good manufacturing practices at manufacturing and distribution facilities, including inadequate validation of OPS sterility.

Conclusion. Bacterial contamination of a nationally distributed product was identified by astute clinicians. The investigation found no illnesses were directly linked to the product. Prompt reporting of concerns about potentially contaminated healthcare products, which might put patients at risk, is critical for swift public health action.

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

135. Outcomes of Kidney Transplantation with a CMV Matching Allocation Schema

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Background. Cytomegalovirus (CMV) infection continues to be a major cause of morbidity in kidney transplant recipients. The CMV donor-positive (D+)/recipient-negative (R–) serostatus pairing poses highest risk for CMV disease.

Methods. In September 2012, we adopted a CMV matching allocation policy at the centers served by our organ procurement organization, the Pacific Northwest Transplant Bank. CMV serostatus was used as a criterion in determining deceased donor kidney allocation, whereby R– kidney transplant recipients were preferentially paired with a D– organ, and R+ recipients with an R+ organ. We performed a retrospective analysis of CMV-related outcomes for 400 consecutive kidney recipients, 196 prior to (January 1, 2010– August 31, 2012) and 204 following (September 1, 2012–December 3, 2014) implementation of the CMV matching allocation schema at our center. We also looked at waitlist time for patients transplanted during the same period.

Results. The percentage of D+/R– transplants performed decreased from 17.3% to 2.5% ($P < 0.001$) after implementation of the CMV matching allocation strategy (Figure 1). CMV viremia decreased from 13.3% to 5.9% ($P = 0.0118$), and CMV syndrome or disease decreased from 9.2% to 2.9% ($P = 0.00859$) (Table 1). The percentage of patients treated for CMV infection overall decreased from 10.7% to 5.4% ($P = 0.0498$). Median days on the waitlist prior to transplantation increased from 793 (PRE) to 944 (POST) due to growing wait list size, but neither R– nor R+ patients appeared to be disadvantaged: wait times increased from 808.5 to 958 for the R– subset and from 777.5 to 933 for the R+ subset (Figure 2).

Conclusion. CMV disease occurred infrequently in our cohort, in the context of 6 months of valganciclovir prophylaxis post-transplant and post-prophylaxis pre-emptive monitoring strategy for our D+/R– recipients. Following implementation of an allocation schema that took CMV serostatus into account, the rate of CMV infection and antiviral treatment decreased significantly.