

healthcare costs suggest an unmet need for improved prescribing practices for uUGG in the US.

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1359. Reported Neurologic, Ocular, and Otic Manifestations among Syphilis Cases — 16 States, 2019

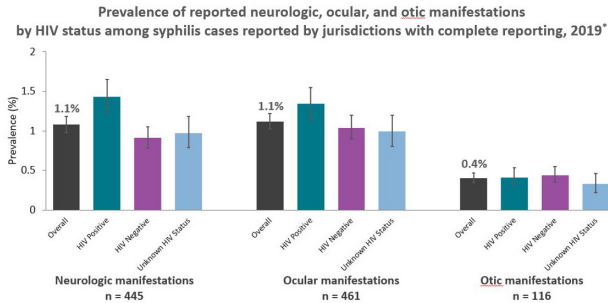
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Session: P-75. Sexually Transmitted Infections

Background. Syphilis can cause neurologic, ocular, or otic manifestations at any stage, possibly resulting in permanent disability or even death. In 2018, CDC began collecting clinical manifestation data for syphilis cases reported through the National Notifiable Diseases Surveillance System (NNDSS). We present the first estimates of the prevalence of neurologic, ocular, and otic manifestations among syphilis cases in the United States.

Methods. We reviewed NNDSS data to identify jurisdictions (states + DC) who reported $\geq 70\%$ of their syphilis cases with clinical manifestation data (considered to have “complete reporting”) in 2019. Among these jurisdictions, we determined the prevalence of neurologic, ocular, and otic manifestations (combining verified, likely, and possible clinical manifestations together), stratified by HIV status and by syphilis stage (Unknown/late syphilis vs. Early syphilis [Primary, Secondary, and Early non primary non secondary syphilis]).

Results. In 2019, 16 states had complete reporting for neurologic, otic, and ocular manifestations. Of the 41,216 syphilis cases reported in these jurisdictions, clinical manifestations were infrequently reported: neurologic (n=445, 1.1%), ocular (n=461, 1.1%), and otic (n=166, 0.4%). Prevalence was higher among HIV-infected persons compared to HIV-negative persons for neurologic (1.4% vs. 0.9%) and ocular manifestations (1.3% vs 1.0%) but was similar for otic manifestations (0.4% vs 0.4%). Prevalence was higher among persons diagnosed with Unknown/late syphilis compared to Early syphilis for neurologic (1.6% vs 0.8%) and ocular manifestations (1.6% vs 0.9%) but similar for otic manifestations (0.5% vs 0.4%); however, 49.4% of cases reported with ≥ 1 of these clinical manifestations were diagnosed with Early syphilis.



*Values shown for prevalence represent the total of verified, likely, and possible neurologic, ocular, and otic clinical manifestations with 95% confidence intervals included. Among 41,216 reported syphilis cases included in this analysis, 12,556 were HIV-infected persons; 18,513 were HIV-negative persons; and 10,147 were persons of unknown HIV status. A total of 316 states reporting $\geq 70\%$ of syphilis cases with nonmissing/unknown clinical manifestation response values were considered to have complete reporting.

Conclusion. The prevalence of neurologic, ocular, and otic manifestations was low among syphilis cases, but case data likely underestimate the true burden given potential underreporting. The frequency of clinical manifestations, including among HIV-negative persons and persons diagnosed with Early syphilis, emphasizes the importance of evaluating all syphilis cases for clinical signs or symptoms regardless of stage or HIV status.

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1360. Prevalence of Bacteremia in Hospitalized Patients with Skin and Soft Tissue Infections (SSTI)

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Session: P-76. Skin and Soft Tissue

Background. Skin and soft tissue infections (SSTI) are common in outpatient and inpatient settings. The prevalence of positive blood cultures (BC) ranges from 2% to 52%. Because of the variations in published data, the exact prevalence of bacteremia in hospitalized patients with SSTI is unknown. Our objective is to determine the prevalence of bacteremia in hospitalized patients with SSTI.

Methods. Retrospective chart review from January 2017 to December 2018. Patients older than 18 years admitted with SSTI who required BC on admission were

included. Patients who met the criteria for systemic inflammatory response syndrome (SIRS)/sepsis or severe SSTI, or had an underlying immunodeficiency underwent BC collection. Patients with diabetic foot ulcer, device related SSTI, necrotizing fasciitis, and osteomyelitis were excluded. Patients were divided into 3 groups: true positive (TP) defined as a true pathogen, false positive (FP) defined as a contaminant, and true negative (TN) defined as no growth in BC. Physician assessment, microorganisms isolated, number of positive bottles/culture sets, and timing of growth were reviewed. Patients' comorbidities, presence of SIRS, laboratory data, duration of antibiotic use, and length of stay (LOS) were compared.

Results. We screened 583 patients and included 541 patients. The mean age was 62 ± 18.4 years, and 60% were male. 47/ 541 (8.6%) had skin abscesses. 57 patients (11%) had positive BC, of whom 32 were TP (6%), and 25 were FP (5%). 89% of patients (484) had TN BC. The organisms isolated are described in Figures 1 and 2. Patients in the FP and TN groups had prior antibiotic use, compared to TP (P < 0.05). The FP group had a longer LOS and duration of antibiotic use compared to the TN group (p < 0.05). 76% of FP had repeated BC. Beta-lactam antibiotics were mostly used, followed by anti-MRSA antibiotics (40%). We did not find risk factors to predict the likelihood of bacteremia. The outcome was not different among the 3 groups.

Figure 1. Microorganisms isolated from blood cultures of patients with SSTI – True pathogens

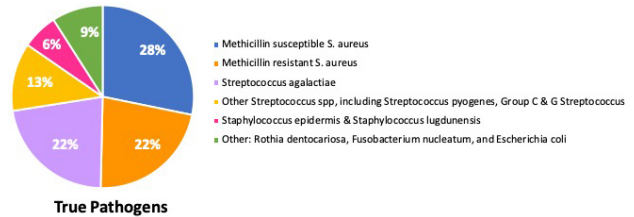
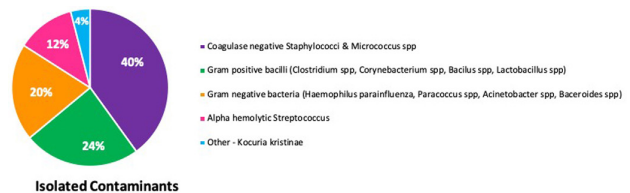


Figure 2. Microorganisms isolated from blood cultures of patients with SSTI – Isolated contaminants



Conclusion. There was a low incidence of true bacteremia (6%) in hospitalized patients with SSTI. More than 90% of TP were predictable causal microorganisms, which are covered by empiric antibiotics. BC may not affect the initial treatment of SSTI. FP BC were associated with an increased LOS, longer antibiotic use, and increased healthcare cost.

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1361. Actinotignum schaalii an Under-recognized Cause of Infections: A Case Series in Calgary from 2012 - 2020

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Session: P-76. Skin and Soft Tissue

Background. Actinotignum schaalii is a gram-positive rod that is a fastidious commensal of the urogenital tract. Infections with A. schaalii are underdiagnosed previously because phenotypic methods fail to identify it. Both MALDI-TOF mass spectrometry and 16S rRNA sequencing allow definitive identification of this opportunistic emerging pathogen. A. schaalii is an infrequent but important cause of UTIs in the elderly, particularly with urological abnormalities. The spectrum of invasive disease caused by A. schaalii is not well characterized; however, it has been isolated in severe infections including necrotizing skin and soft tissue infections, bacteremia, osteomyelitis, and endocarditis. We used a population-based approach to characterize and describe the clinical and microbiological features of invasive A. schaalii infections in our region.

Methods. All adult and pediatric cases enrolled had microbiological isolates of Actinotignum schaalii recovered from blood cultures, sterile fluids and tissue cultures from Jan 2012 to Dec 2020 by APL, a regional centralized microbiology laboratory serving the Calgary Zone in Alberta, Canada. Clinical data were retrieved and linked from administrative health databases, chart review and the laboratory information system. Standard descriptive statistics were used.

Results. We identified 84 unique A. schaalii infections, 35 were from bloodstream, 32 soft tissue, 7 post-operative infections. Median age and Charlson comorbidity score was higher in BSI. 54.3% of patient with BSI had a genitourinary pathology, with 51.4% caused by a complicated urinary infection, while soft and skin tissue infections caused 65.3% of non-BSI. Using EUCAST MIC cut-offs, 48% and 100% of the isolates were resistant to clindamycin and metronidazole, respectively. In contrast, all specimens were susceptible to penicillin. Hospitalization and 90-days mortality were higher in the BSI group.