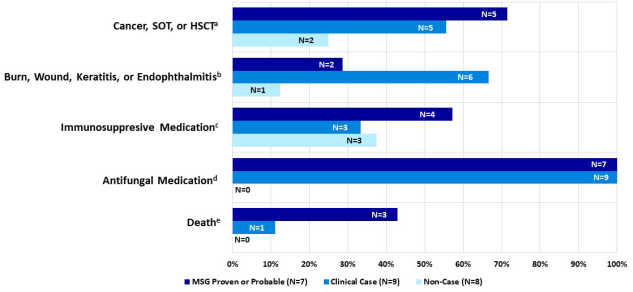
Table 1: Site of Incident Specimen and Mold Species Identification

	MSG Proven or Probable (N=7)	Clinical Case (N=9)	Non-case (N=8)
	N	N	N
Site of Specimen			
Pulmonary	3	3	2
Sinus, nasal, or facial	0	0	4
Other Skin Lesion	1	1	2
CNS	0	4	0
Other[a]	3	1	0
Final Mold Identification			
Aspergillus	5	2	2
Mucormycetes	1	0	0
Fusarium	1	2	0
Other[b]	0	5	6

[a]Other sites of specimen: soft tissue, blood/serum
[b]Other molds: *Curvularia* (*Bipolaris*), *Exophiala*, *Acremonium*, *Cladosporium*, *Paecilomyces*

Figure 2: Attributes of IMI Cases and Non-cases from March 2017-March 2018 (N = 24)



[a]SOT: Solid organ transplant; HSCT: hematopoietic stem cell transplant
[b]These conditions were grouped because they are clinical IMI presentations not covered by MSG
[c]Includes corticosteroids, biologics, TNF inhibitors
[d]Includes any systemic mold-active antifungal medication and eye drops
[e]Death occurring within 60 days of incident mold specimen

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

1715. Coccidioidomycosis Outcomes Among Hospitalized Pregnant and Postpartum Women—California, 2000–2016

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Background. Coccidioidomycosis (CM) in pregnancy has been associated with severe, disseminated disease. Publications are largely limited to case reports. Using California administrative hospital and birth registry data, we describe maternal and neonatal outcomes among pregnant and post-partum women hospitalized with CM.

Methods. We extracted California records from 2000 to 2016 for women 14–45 years, hospitalized with CM discharge codes; and used the birth registry to identify women who were pregnant or post-partum (≤30 days of childbirth) during their hospitalization. We used chi-squared tests to compare pregnant/post-partum women hospitalized with CM to nonpregnant women hospitalized with CM, and birth outcomes for infants of mothers hospitalized with CM to other California infants. We used multivariable logistic regression, controlling for demographics and comorbidities, to determine the risk of pregnancy on CM dissemination.

Results. We identified 2,372 women with ≥1 CM hospitalization; 187 (8%) were pregnant/post-partum and there were 188 infants (one set of twins). Pregnant/post-partum women were more likely to be Hispanic (59% vs. 44%, $P < 0.01$), younger (median age 27 vs. 35 years, $P < 0.01$), without comorbidities (60% vs. 36%, $P < 0.01$), and have disseminated CM (32% vs. 21%, $P < 0.01$) than nonpregnant women. Hospitalized pregnant/post-partum women with CM were more likely to have CM dissemination compared with hospitalized non-pregnant women with CM (odds ratio 2.0, 95% confidence interval 1.4–2.8). Among infants of pregnant women hospitalized with CM, 18 (10%) were born < 34 weeks gestational age and 11 (8%) of 134 term (>37 weeks) infants had a birth weight <2,500 g; compared with 3% and 3% ($P < 0.01$) of other California liveborns, respectively.

Conclusion. This study is the largest cohort of pregnant women hospitalized with CM to date and corroborates that pregnant/post-partum women are more likely to develop disseminated CM than non-pregnant women. Their infants may be more likely to be born <34 weeks gestational age and have a low birth weight. This highlights the need for clinicians caring for pregnant/post-partum women who may live or travel to an area where CM occurs to be aware of the risks for these women and their infants.

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

1716. Baseline Serum C-Reactive Protein Level Predicts Mortality in Cryptococcal Meningitis

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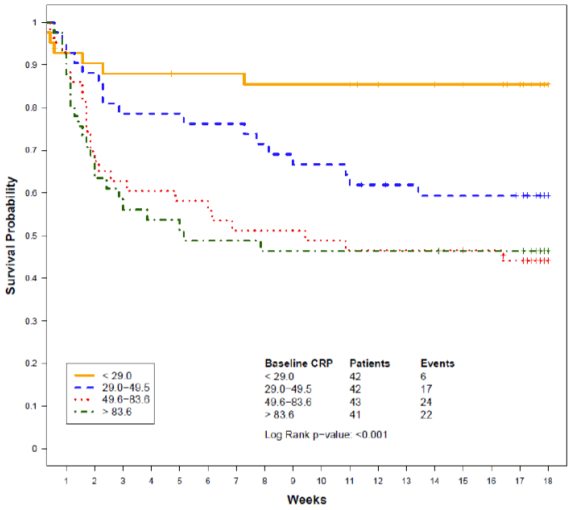
Background. C-reactive protein (CRP) is an acute-phase protein produced by the liver in response to systemic inflammation. CRP is a helpful surrogate biomarker widely used in various infections, particularly for following the progression and resolution of infection. We aimed to determine the association between baseline CRP level and cryptococcal meningitis outcome.

Methods. We reviewed 168 prospectively enrolled HIV-infected Ugandans with confirmed first-episode cryptococcal meningitis. Baseline serum samples collected within 5 days from diagnosis had CRP levels measured and categorized into quartiles. We compared baseline serum CRP with 18-week survival using unadjusted time-to-event analysis.

Results. Of 168 participants, the first quartile of baseline serum CRP was 83.6 mg/L. Baseline CD4 count, HIV viral load, and cerebrospinal fluid results did not differ by quartile. Participants with CRP > 49.5 mg/L more likely presented with Glasgow Coma Scale <15 ($P = 0.03$). The 18-week mortality rate was 54.8% (46/84) in the highest two quartile CRP groups (49.5 mg/L), 40.5% (17/42) in the mid-range CRP group (29–49.5 mg/L), and 14.3% (6/42) in the low CRP group (<29 mg/L) ($P < 0.001$) (Figure 1).

Conclusion. Higher baseline serum CRP is associated with increased mortality in HIV-infected individuals with first-episode cryptococcal meningitis. The serum CRP could be a surrogate marker for undiagnosed co-infections or may reflect immune dysregulation leading to worse outcomes in persons with advanced AIDS and concomitant cryptococcal meningitis. Additional studies investigating more specific inflammatory biomarkers and the longitudinal trend in CRP with effective therapy would be informative.

Figure 1. Kaplan-Meier plot of cumulative survival stratified by baseline serum CRP quartiles



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

1717. Cryptococcal Meningitis: A Comparison of Clinical Features and Outcomes by HIV Status

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Background. Cryptococcal meningitis is an opportunistic fungal infection associated with HIV and other forms of immunosuppression. We lack a clear understanding of cryptococcal meningitis (CM) among HIV-negative patients in the United States. Our aim was to compare clinical features and outcomes across HIV status in patients with laboratory-confirmed cryptococcal meningitis.

Methods. We conducted a retrospective cohort study of patients with laboratory-confirmed (positive culture or antigen test) cryptococcal disease treated at a tertiary care center from January 2000 to September 2018. Patients were identified via local laboratory and TrinetX datasets. Data were gathered on demographics, HIV status, site of infection, clinical presentation, cerebrospinal fluid (CSF) profiles, hospital course, and mortality. Organ transplant recipients and/or non-meningeal infections were excluded.

Results. Seventy patients with cryptococcal disease were identified. Our final sample included 36 CM patients with a mean age of 48.8 ± 13.2 years; 66.7% (n = 24) had HIV. Median (IQR) absolute CD4 count for the HIV group was 35/μL (10–80/