without COVID-19. The nature of the potential relationship between comorbidities, mucormycosis, and COVID-19 should be explored further.

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122. Impact of Infectious Diseases Consultation in Patients with Candidemia at a Large Multi-site Healthcare System Providing Telemedicine Services

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Session: O-25. New Findings in Medical Mycology

Background. *Candida* species are the most common cause of fungemia and are associated with high mortality. Management concordant with the Infectious Diseases Society of America guidelines and infectious diseases consultation (IDC) have been shown to lower mortality in patients with candidemia. The purpose of this study was to compare in-hospital mortality at a large multi-site healthcare system, including sites providing IDC via telemedicine services, in patients with candidemia with and without IDC.

Methods. This was a retrospective, observational cohort study completed at ten sites of Legacy Atrium Health in Charlotte Metro, NC, USA; at five sites, IDC is performed via telemedicine. Adult hospitalized patients identified with candidemia were enrolled May 2018-June 2019. The primary outcome was in-hospital mortality of IDC and non-IDC patients. Secondary outcomes included obtainment of repeat blood cultures, receipt of antifungal treatment, duration of therapy, removal of central venous lines (CVC) when present, and ophthalmological examination. Fisher's exact, Chi-Square, or two-tailed Student's t-test were used for demographics, primary and secondary outcomes as appropriate.

Results. A total of 126 patients were enrolled: 103 (82%) in the IDC group and 23 (18%) in the non-IDC group (Table 1). Mortality was significantly lower, and rates of repeat blood culture obtainment and receipt of antifungal treatment were significantly higher in patients with IDC (Table 2). Other outcomes including duration of therapy, removal of CVC, repeat cultures within 48 hours, and ophthalmological examination were not statistically different between groups.

Table 1: Infectious Diseases Consultation (IDC) and Non-IDC Demographics

	ID Consult (n=103)	Non-ID Consult (n=23)	P value
Age (years), mean	59	66	0.09
Weight (kg), mean	81.1	83.3	0.75
Recent Azole Exposure, n (%)	12/103 (12%)	2/23 (9%)	0.99
Empiric Antifungal Treatment, n (%)			
• Fluconazole, 34 (30%)	28/101 (28%)	6/13 (46%)	0.20
• Echinocandin, 79 (69%)	72/101 (71%)	7/13 (54%)	0.21
• Other, 3 (3%)	3/101 (3%)	0/13 (0%)	0.99
Empiric Dosing (mg), mean			
• Fluconazole	364.3	333.3	0.57
• Echinocandin	51.1	50	0.82
Definitive Antifungal Treatment, n (%)			
• Fluconazole, 67 (63%)	59/96 (61%)	8/11 (73%)	0.53
• Echinocandin, 37 (35%)	34/96 (35%)	3/11 (27%)	0.74
• Other, 4 (4%)	4/96 (4%)	0/11 (0%)	0.99
Definitive Dosing (mg), mean			
• Fluconazole	433.9	375	0.39
• Echinocandin	54.6	50	0.75
Organism Distribution, n (%)			
• *Candida albicans*, 45 (35%)	35/104 (34%)	10/24 (42%)	0.48
• *Candida glabrata*, 44 (34%)	38/104 (37%)	6/24 (25%)	0.35
• *Candida parapsilosis*, 16 (13%)	12/104 (12%)	4/24 (17%)	0.50
• *Candida tropicalis*, 11 (9%)	8/104 (8%)	3/24 (13%)	0.43
• *Candida krusei*, 9 (7%)	9/104 (9%)	0/24 (0%)	0.21
• Candida Other, 3 (2%)	2/104 (2%)	1/24 (4%)	0.47
Antifungal Resistance, n (%)			
• Fluconazole Resistance	11/94 (12%)	1/21 (5%)	0.69
• Echinocandin Resistance	0/20 (0%)	0/2 (0%)	0.99
Hospital Length of Stay (days), mean	21.3	12.5	0.07
Neutropenia, n (%)	4/103 (4%)	0/23 (0%)	0.99
Renal Dysfunction, n (%)	48/103 (47%)	16/23 (70%)	0.06
Hepatic Dysfunction, n (%)	71/103 (69%)	18/23 (78%)	0.45

Table 2: Infectious Diseases Consultation (IDC) and Non-IDC Outcomes

	ID Consult (n=103)	Non-ID Consult (n=23)	P value
In-hospital Mortality, n (%)	14/103 (14%)	12/23 (52%)	< 0.05
Repeat Blood Culture Obtained, n (%)	97/103 (94%)	10/23 (44%)	< 0.05
Receipt of Antifungal, n (%)	101/103 (98%)	13/23 (56%)	< 0.05
Duration of Antifungal (days), mean	14.9	12.3	0.51
Removal of Central Venous Lines, n (%)	54/64 (84%)	6/10 (60%)	0.09
Repeat Blood Culture within 48 Hours, n (%)	30/103 (29%)	3/23 (13%)	0.19
Ophthalmological Examination, n (%)	20/103 (19%)	1/23 (4%)	0.12

Conclusion. This study is the first multi-site healthcare system providing telemedicine services to evaluate the impact of IDC on candidemia mortality. Ophthalmological examination rates were low in both groups, highlighting a potential area for improvement. IDC had significantly lower mortality, higher rates of antifungal treatment, and higher rates of repeat blood culture obtainment. IDC should be strongly considered in all patients with candidemia.

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123. Oral Ibrexafungerp Outcomes by Fungal Disease in Patients from an Interim Analysis of a Phase 3 Open-label Study (FURI)

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FURI Study Group

Session: O-25. New Findings in Medical Mycology

Background. *Candida* species are a major cause of invasive and mucocutaneouls infections. There are limited oral treatment options available for patients with *Candida* infections who are unresponsive to or who are intolerant of currently available antifungals. Oral ibrexafungerp is an investigational broad-spectrum glucan synthase inhibitor antifungal with activity against *Candida* and *Aspergillus* species, including azole- and echinocandin-resistant strains. A Phase 3 open-label, single-arm study of ibrexafungerp (FURI; NCT03059992) is ongoing for the treatment of patients intolerant of or with fungal disease refractory to standard antifungal therapy. We present an analysis of patient outcomes from the FURI study by fungal disease type.

Table 1: FURI Outcomes by Fungal Disease

	N	Complete or Partial Response, Clinical Improvement N (%)	Stable Response N (%)	Progression of Disease N (%)	Indeterminate N (%)
Invasive Candidiasis					
Candidemia	11	8 (72.7%)	1 (9.0%)	1 (9.0%)	1 (9.0%)
Intra-abdominal infections	14	7 (50%)	3(21.4%)	2 (14.2%)	1 (7.1%)
Bone/joint	8	5 (62.5%)	2 (25%)		1 (12.5%)
Urinary tract infection	1		1 (100%)		
Subcutaneous wound infection	2	2 (100%)			
Mediastinitis	1	1 (100%)			
Empyema	1	1 (100%)			
Endocarditis	1	1 (100%)			
Mucocutaneous Candidiasis					
Oropharyngeal candidiasis	14	9 (64.3%)	3 (21.4%)	2 (14.3%)	
Esophageal candidiasis	10	6 (60%)	4 (40%)		
Vulvovaginal candidiasis	7	5 (71.4%)	1 (14.3%)		1 (14.3%)
Chronic mucocutaneous candidiasis-skin	1		1 (100%)		
Invasive Aspergillosis					
Pulmonary	3	2 (66.7%)	1 (33.3%)		

1 Death, not related to fungal disease

Methods. FURI patients were eligible for enrollment if they have proven or probable, severe mucocutaneous candidiasis, invasive candidiasis or invasive aspergillosis,other fungal diseases and evidence of failure to, intolerance to, or toxicity related to a currently approved standard-of-care antifungal treatment or can not receive approved oral antifungal options (e.g., susceptibility of the organism) and a continued IV antifungal therapy is clinically undesirable or unfeasible.

Results. An independent Data Review Committee (DRC) provided an assessment of treatment response for 74 patients enrolled in the FURI study from 22 centers in US, UK and EU treated with ibrexafungerp for mucocutaneous or invasive fungal infections from 2016- 2020. A total of 39 (52.7%) patients had invasive candidiasis, 32 (43.2%) had mucocutaneous candidiasis and 3 (4.5%) patients had invasive aspergillosis. The percent of patients who were determined to have a complete response (CR), partial response (PR), clinical improvement (CI) was 63.5%, stable disease (SD) was 23.0%, patients with progression of disease 6.8% and 4 patients were indeterminate. Additionally, there was 1 death in the FURI study that was not related to fungal disease. Table 1 shows outcomes by fungal disease type as determined by the DRC.

Conclusion. Analysis of 74 patients from the FURI study indicates that oral ibrexafungerp provides a favorable therapeutic response in patients with challenging fungal disease and limited treatment options.

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124. Establishment of a Post-Influenza Aspergillosis Model in Corticosteroid-Immunosuppressed Mice

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Session: O-25. New Findings in Medical Mycology

Background. Post-influenza aspergillosis (PIA) is a feared complication in patients with severe influenza, especially those receiving corticosteroids. However, validated murine models of PIA in a background of corticosteroid immunosuppression are lacking, compounding efforts to better characterize the immunopathology and treatment of this emerging entity.

Methods. 8-week-old female BALB/c mice were infected with ~5% of the lethal dose of a mouse-adapted influenza A/Hong Kong/1968 (H3N2) strain (flu), delivered by aerosolization, versus control (aerosolized saline). Mice then received two intraperitoneal injections of 10 mg cortisone acetate (CA) or mock injections on days 5 and 8 after flu infection. On day 9, mice were intranasally challenged with 50,000 *A. fumigatus* AF-293 conidia or mock-infected with