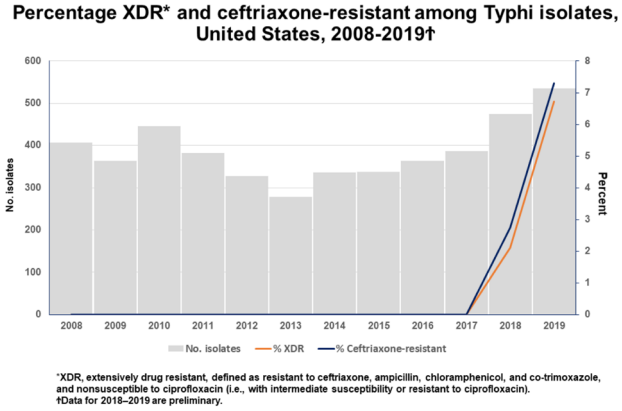

Disclosures. **All Authors**: No reported disclosures

166. Congenital Syphilis in Minnesota, 2016-2020

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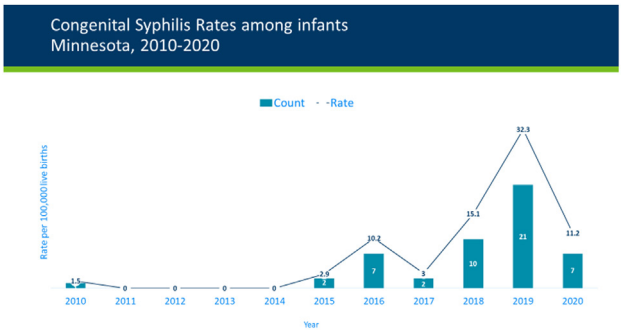
Session: O-33. STIs and Enteric Infections

Background. Nationally, cases of congenital syphilis (CS) have increased over the past 5 years. We reviewed CS cases in Minnesota from 2016-2020.

Methods. All cases of syphilis, including CS, are reported to the Minnesota Department of Health (MDH), including accompanying data on maternal age, baby's sex, race, test results, maternal stage and treatment of mother and child. Medical records and case interviews were reviewed; the 2018 national case definition was used to classify cases.

Results. During 2016-2020, there were 47 CS cases from 45 mothers, peaking in 2020 at a rate of 3.2/10,000 live births. 43 (91.5%) cases of CS had no clinical signs, 1 (2.1%) CS case was inadequately treated, and there were 2 deaths.

The median maternal age was 28 (IQR 9, range 18-38). 13 (28.9%) identified as Black, non-Hispanic, 13 (28.9%) as American Indian/Alaska Native (AI/AN), 9 (20.0%) as White, non-Hispanic, 3 (6.7%) as Hispanic, 2 (4.4%) as Asian/Pacific Islander, and 5 (11.1%) Other/Unknown. Twenty-four (51.1%) cases occurred in the Minneapolis/St. Paul metropolitan area. 2 (4.4%) cases were primary, 1 (2.2%) was secondary, while 18 (40.0%) maternal cases were staged as early non-primary, non-secondary (ENPNS) and 24 (53.3%) were late unknown duration. 14 (31.1%) of mothers had their initial prenatal visit in the first trimester, 6 (13.3%) in the 2nd trimester, 11 (24.4%) in the 3rd, and 14 (31.1%) unknown. None of the maternal cases were HIV+, 2 were identified as positive for hepatitis C. 18 (40.0%) mothers had no or limited prenatal care, 21 (46.7%) had inadequate treatment for syphilis, and 18 (40.0%) had inadequate maternal testing. No cases reported substance use, but one case had a positive substance screen at delivery, and case interviews also documented a role of substance use and home instability in several other cases.



Conclusion. Case rates of CS are the highest ever seen in MN. There is disproportionate impact in persons of color and indigenous Minnesotans. Lack of access to prenatal care, missed opportunities for testing, and incomplete or insufficient treatment were found in maternal cases. More work needs to be done with communities at risk and with prenatal care providers to ensure adequate testing, identification and treatment for syphilis in women of child-bearing age.

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

167. Efficacy of Investigational Microbiota-Based Live Biotherapeutic RBX2660 in Individuals with Recurrent *Clostridioides difficile* Infection: Data from Five Prospective Clinical Studies

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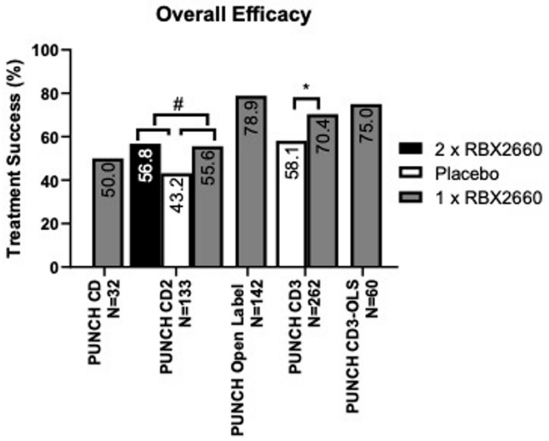
Session: O-33. STIs and Enteric Infections

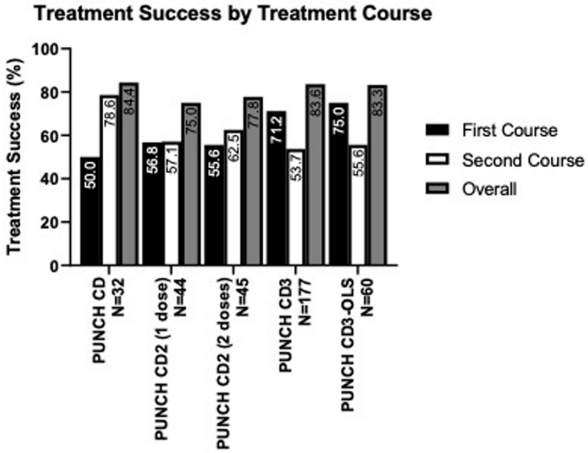
Background. Microbiota-based treatments have shown promise to reduce recurrence, morbidity, and mortality for recurrent *Clostridioides difficile* infections (rCDI), but consistent and reliable clinical efficacy data are needed to support regulatory approvals that broaden patient access. Here we provide cumulative data from 5 prospective clinical studies evaluating RBX2660—a standardized, microbiota-based investigational live biotherapeutic—for reducing rCDI recurrence.

Methods. This analysis included three phase 2 (PUNCH CD, PUNCH CD2, PUNCH CD Open Label) and two phase 3 trials (PUNCH CD3, PUNCH CD3-OLS *ad hoc* analysis). All participants were ≥18 years old with documented rCDI who completed standard-of-care (SOC) oral antibiotic therapy prior to treatment with RBX2660. Depending on the trial, assigned study treatment was 1 or 2 doses of RBX2660 or placebo, with Treatment Success (TS) defined as remaining recurrence-free for 8 weeks after treatment. Treatment responders were monitored for additional recurrence through at least 6 months after receiving the last RBX2660 dose. Treatment non-responders were administered SOC antibiotic treatment and/or additional RBX2660 treatment and monitored for recurrence for 8 weeks after the last received RBX2660 treatment.

Results. Among the 5 trials with a total of 629 participants, RBX2660 consistently reduced the recurrence of rCDI, with TS rates ranging from 50 to 78.9% (Figure 1). Among primary non-responders, additional RBX2660 treatments further reduced recurrence and overall rates of TS ranged from 75.0% to 84.4% (Figure 2). Among CD, CD3, and CD3-OLS, a majority of primary responders remained CDI-free to 6 and up to 24 months with success rates ranging from 74.4% to 92.1%.



*, Bayesian hierarchical model; 98.6% (0.986) probability of superiority, which exceeded the predefined 0.975 success threshold.
#, Chi-square test; p>0.05.
PUNCH CD3-OLS: enrolled subjects with IBD, IBS, Immunocompromised Conditions; Ongoing, *ad hoc* analysis.



PUNCH CD3-OLS: enrolled subjects with IBD, IBS, Immunocompromised Conditions; Ongoing, *ad hoc* analysis.

Conclusion. Among 5 trials with consistent investigational product and clinical endpoints, RBX2660 consistently reduced rCDI recurrence, with a majority of treatment responders remaining CDI-free for at least 6 and up to 24 months. Further, initial lack of response to RBX2660 did not preclude clinical benefit of additional RBX2660

treatment. Collectively, these data demonstrate consistency and reliability of the potential benefit of RBX2660 across an entire clinical program.

Disclosures. **Lindy Bancke, PharmD**, **Rebiotix, a Ferring Company** (Employee) **Xin Su, MD**, **Rebiotix/Ferring** (Employee)

168. Testing, Diagnosis, and Incidence of Sexually Transmitted Infections Among People with Substance Use Disorders in the Veterans Health Administration, 2019

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Session: O-33. STIs and Enteric Infections

Background. People with substance use disorders (SUDs) are at increased risk of acquiring sexually transmitted infections (STIs.) In response to the syndemic of STIs and SUDs, the Department of Health and Human Services' 2020 STI National Strategic Plan called for increased STI testing among people with SUDs and integration of testing and treatment into non-traditional settings. Existing data describing STI testing and incidence rates among people with SUDs are limited to single or regional medical centers. National samples are needed to target interventions. We report on STI testing, test positivity, and incidence rates among people with SUDs who receive medical care in the Veterans Health Administration (VHA).

Methods. We performed a retrospective cohort study of individuals with SUDs who received VHA care in 2018 or 2019. Data were obtained from the Corporate Data Warehouse, a national database that includes data from VHA's electronic medical record. For individuals with alcohol, opioid, cocaine, and/or other stimulant (e.g. methamphetamine) use disorders, we collected demographic data, testing and results for gonorrhea (GC), chlamydia (CT), syphilis, and HIV during 2019. We calculated rates of testing, test positivity, and incidence rates.

Results. Incidence of all four STIs was highest in the other stimulant use disorder group; incidence of syphilis was particularly elevated at 922.4 cases/100K. Veterans with multiple SUDs were three times more likely to be houseless in 2019 than those with a single SUD and had higher incidence of all STIs than those with single SUDs, except for people with other stimulant use disorders. People with alcohol use disorder (AUD) had a higher incidence of GC, CT, and syphilis than those with opioid use disorder despite similar testing rates. Percent positivity for HIV ranged from 0.27% for AUD to 2.0% for other stimulant use disorders.

Table 1. Demographic characteristics of individuals with reported SUD

Variable	Value	People with Alcohol use disorder N=339,516 *n (%)*	People with Cocaine use disorder N=16,537 *n (%)*	People with Opioid use disorder N=33,837 *n (%)*	People with Other stimulant use disorder N=10,408 *n (%)*	People with Single SUD Reported N=400,298 *n (%)*	People with Multiple SUDs Reported N=85,571 *n (%)*
Age at start of CY 2019	*mean (SD)*	55.1 (15.1)	59.3 (10.1)	55.2 (14.7)	49.9 (13.3)	55.2 (14.9)	52.7 (12.9)
Sex	F	21,868 (6.4)	1,145 (6.9)	2,815 (8.3)	1,003 (9.6)	26,831 (6.7)	5,545 (6.5)
	M	317,648 (93.6)	15,392 (93.1)	31,022 (91.7)	9,405 (90.4)	373,467 (93.3)	80,026 (93.5)
Race	Asian American	2,479 (0.7)	45 (0.3)	141 (0.4)	153 (1.5)	2,818 (0.7)	372 (0.4)
	Black	70,558 (20.8)	11,514 (69.6)	4,826 (14.3)	1,166 (11.2)	88,064 (22)	33,427 (39.1)
	Hawaiian/Pacific Islander	3,017 (0.9)	91 (0.6)	216 (0.6)	184 (1.8)	3,508 (0.9)	590 (0.7)
	Native American	3,891 (1.1)	63 (0.4)	303 (0.9)	128 (1.2)	4,385 (1.1)	797 (0.9)
	White	236,467 (69.6)	4,062 (24.6)	26,380 (78)	7,980 (76.7)	274,889 (68.7)	45,921 (53.7)
	Unknown race	19,809 (5.8)	556 (3.4)	1,648 (4.9)	635 (6.1)	22,648 (5.7)	3,450 (4)
	Multiracial	3,295 (1)	206 (1.2)	323 (1)	162 (1.6)	3,986 (1)	1,014 (1.2)
Ethnicity	Hispanic ethnicity	27,217 (8)	830 (5)	1,819 (5.4)	958 (9.2)	30,824 (7.7)	5,964 (7)
Rurality	Urban	231,026 (68)	13,791 (83.4)	23,076 (68.2)	7,253 (69.7)	275,146 (68.7)	66,841 (78.1)
	Rural/Highly Rural	104,415 (30.8)	2,482 (15)	10,326 (30.5)	2,821 (27.1)	120,044 (30)	16,733 (19.6)
	Unknown	4,075 (1.2)	264 (1.6)	435 (1.3)	334 (3.2)	5,108 (1.3)	1,997 (2.3)
Census region	West	69,624 (20.5)	1,650 (10)	7,807 (23.1)	4,586 (44.1)	83,667 (20.9)	15,010 (17.5)
	Midwest	75,910 (22.4)	2,935 (17.7)	6,726 (19.9)	1,784 (17.1)	87,355 (21.8)	17,006 (19.9)
	South	145,542 (42.9)	9,558 (57.8)	13,132 (38.8)	3,346 (32.1)	171,578 (42.9)	38,332 (44.8)
	Northeast	41,847 (12.3)	1,985 (12)	5,651 (16.7)	328 (3.2)	49,811 (12.4)	12,514 (14.6)
	Other	6,593 (1.9)	409 (2.5)	521 (1.5)	364 (3.5)	7,887 (2)	2,709 (3.2)
HIV	People living with HIV in CY 2019	1,833 (0.5)	657 (4)	405 (1.2)	479 (4.6)	3,374 (0.8)	2,243 (2.6)
Living status	Experienced homelessness during FY 2018-19	38,816 (11.4)	4,981 (30.1)	4,144 (12.2)	3,760 (36.1)	51,701 (12.9)	36,943 (43.2)
Mental health diagnoses during CY 2019	Any	233,462 (68.8)	11,087 (67)	23,519 (69.5)	8,247 (79.2)	276,315 (69)	75,432 (88.2)
	Anxiety	98,473 (29)	3,298 (19.9)	10,290 (30.4)	3,451 (33.2)	115,512 (28.9)	34,040 (39.8)
	Bipolar	22,630 (6.7)	1,668 (10.1)	2,387 (7.1)	1,513 (14.5)	28,198 (7)	15,103 (17.6)
	Depression	151,904 (44.7)	6,666 (40.3)	14,209 (42)	4,844 (46.5)	177,623 (44.4)	53,568 (62.6)
	PTSD	126,907 (37.4)	4,475 (27.1)	11,433 (33.8)	3,764 (36.2)	146,579 (36.6)	40,957 (47.9)
	Schizophrenia	9,866 (2.9)	1,705 (10.3)	725 (2.1)	989 (9.5)	13,285 (3.3)	8,239 (9.6)
	Other mental health	33,809 (10)	2,043 (12.4)	3,673 (10.9)	1,716 (16.5)	41,241 (10.3)	19,496 (22.8)

Table 2. STI testing, percent positivity, and case rate by SUD diagnosis in 2019: single and multiple SUDs

STI	SUD reported	N	Percent of pts tested	Percent positivity of testing	Unique pts with new diagnosis *n (%)*	Cases per 100k
Chlamydia	**Alcohol**	339,516	4.4	3.7	633 (0.2)	196.5
	Cocaine	16,537	7.3	2.4	35 (0.2)	211.6
	Opiates	33,837	3.2	2.6	31 (0.1)	91.6
	Other stimulant	10,408	9.7	4.8	63 (0.6)	672.6
	Multiple	85,571	9.8	2.7	264 (0.3)	326
Gonorrhea	**Alcohol**	339,516	4.4	2.1	360 (0.1)	111.9
	Cocaine	16,537	7.3	3.9	58 (0.4)	368.9
	Opiates	33,837	3.2	2.1	25 (0.1)	76.8
	Other stimulant	10,408	9.7	6.3	86 (0.8)	883.9
	Multiple	85,571	9.8	3.7	357 (0.4)	449.9
Syphilis	**Alcohol**	339,516	6.6	0.8	202 (0.1)	60.1
	Cocaine	16,537	11.9	2.1	45 (0.3)	296.3
	Opiates	33,837	6.5	0.5	12 (0)	35.5
	Other stimulant	10,408	12.1	5.6	92 (0.9)	922.4
	Multiple	85,571	19.6	1.2	252 (0.3)	298
HIV*	**Alcohol**	337,793*	12.7	0.27	110 (0.03)	32.6
	Cocaine	15,898*	17.9	0.52	18 (0.1)	113.2
	Opiates	33,441*	11.6	0.41	9 (0.03)	26.9
	Other stimulant	9,966*	18.6	2.0	37 (0.4)	371.3
	Multiple	83,421*	28.0	0.44	93 (0.1)	111.5

*Denominators exclude people who are living with HIV at the start of CY 2019

Conclusion. High incidence of STIs among people with non-cocaine stimulant use disorder indicates a need for comprehensive testing. The data suggests that veterans with AUD would benefit from increased testing. Houselessness and mental health diagnoses were common, and comprehensive STI testing and treatment programs, including an assessment of HIV risk, should be integrated into programs addressing these comorbidities.

Disclosures. **Holly Villamagna, MD**, Nothing to disclose

169. The Resurgence of *Candida auris* in California during the Novel Coronavirus (COVID-19) Pandemic, May 2020–May 2021

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Session: O-34. The Interplay Between COVID and other Infections

Background. In February 2019, California (CA) experienced its first *C. auris* outbreak in Orange County (OC). The CA Department of Public Health (CDPH) and OC with the Centers for Disease Control and Prevention (CDC), mounted a successful containment response; by November 2019, cases were limited to low-level spread in OC long-term acute care hospitals (LTACH).

In May 2020, *C. auris* cases began to surge in OC, followed by extensive spread in six other southern CA local health jurisdictions (LHJ). CDPH with LHJ and CDC, initiated an aggressive, interjurisdictional containment response.

Methods. We carried out response and preventive point prevalence surveys (PPS), onsite infection prevention and control (IPC) assessments, and in-service trainings at outbreak and interconnected hospitals and skilled nursing facilities in six LHJ. Other regional activities included: epidemiologic investigation, contact and discharge tracking and screening; increasing laboratory testing capacity; screening patients admitted to and from LTACH; statewide healthcare facility (HCF) education