no association between HCV D+/R+ and increasing risk of rejection (HR 0.92, 95% CI 0.43–1.95, $P > 0.20$) or mortality (HR 0.93, 95% CI 0.42–2.1, $P > 0.20$). In a multivariate analysis, age was the only independent risk factor for HCV D+/R+ mortality (HR = 1.09, 95% CI 1.03–1.14, $P < 0.001$).

Conclusion. Patients who are HCV-positive did not have worse mortality or graft rejection if they received HCV-positive kidneys compared with HCV-negative kidneys. Providers can use these data to give specific risk information to HCV-positive patients about accepting an HCV-positive kidney for transplant, even perhaps encouraging it. Increasing the utilization of HCV-positive kidneys for transplantation in the era of effective DAA has the potential to offer life-saving treatment to substantially more patients.

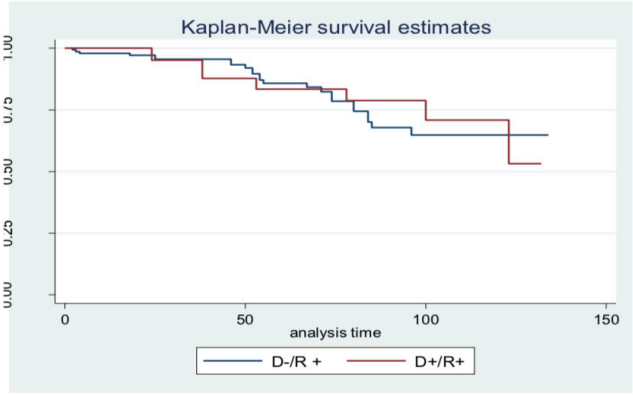

Figure 1. Kaplan-Meier estimates of survival in HCV D-/R+ v HCV D+/R- recipients

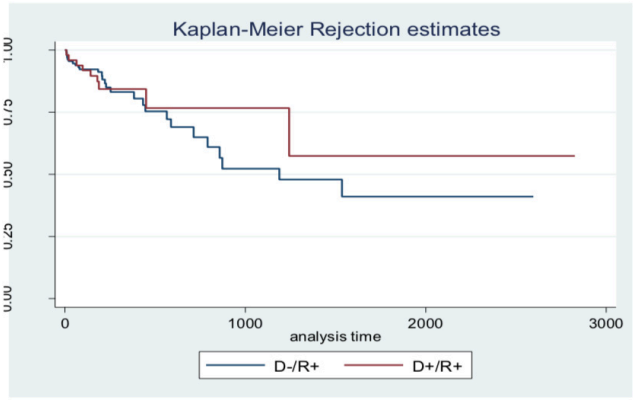

Figure 2. Kaplan-Meier estimates of graft rejection in HCV D-/R+ v HCV D+/R- recipients

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

1758. Epidemiology of Invasive *Mycoplasma* and *Ureaplasma* Infections Early after Lung Transplantation

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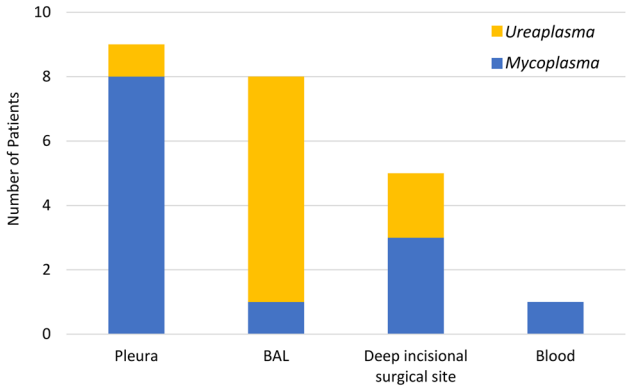
Background. *Mycoplasma* and *Ureaplasma* species can cause invasive infections early after lung transplant that are difficult to diagnose and associated with substantial morbidity, including hyperammonemia syndrome. Data on the epidemiology and clinical outcomes of these infections are needed to inform clinical management and screening protocols for donors and recipients.

Methods. We retrospectively collected clinical data on all patients who underwent lung transplantation at our hospital from January 1, 2010 to April 15, 2019 and subsequently had positive cultures or PCR studies for *M. hominis* or *Ureaplasma* spp. Patients with positive studies from only the genitourinary tract were excluded. We analyzed donor and recipient clinical characteristics, treatment courses, and outcomes for up to 2 years after transplant.

Results. Of 1055 total lung transplant recipients, 20 (1.9%) patients developed invasive infection with *M. hominis* or *Ureaplasma* spp. *M. hominis* caused the first 10 infections (2010–2016), and *Ureaplasma* spp. caused 10 subsequent infections (2017–2019). Date of first positive culture or PCR study occurred a median of only 19 days after transplant (range, 4–90 days). Median donor age was 31 years (range, 18–45 years), and chest imaging for 16 (80%) donors revealed airspace disease compatible with aspiration. Infection outside of the respiratory tract was confirmed for 13 (65%) recipients, including 8 patients with *M. hominis* empyemas (Figure 1). Ten (50%) patients developed altered mental status that was temporally associated with infection; 8 (80%) of these patients had elevated serum ammonia levels, including 3 patients with *M. hominis* infection. Median duration of therapy was 6 weeks (IQR, 4–9 weeks), consisting of combination antimicrobial regimens for nearly all patients. Additional postoperative complications were common, and 11 (55%) patients died within 1 year after transplant (median, 117 days; IQR, 65–255 days) (Figure 2).

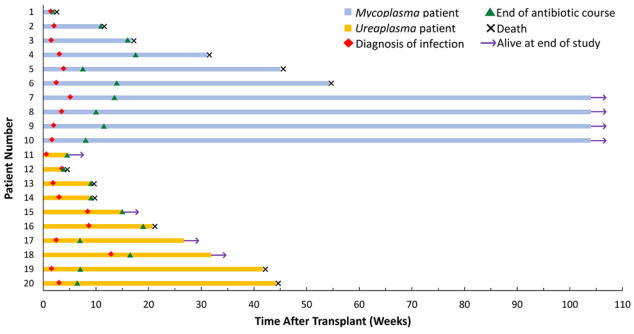
Conclusion. *Ureaplasma* and *M. hominis* infections occurred early after lung transplant and were associated with substantial morbidity and mortality. Transplant clinicians should have low thresholds for performing specific diagnostic testing for these organisms. Protocols for donor and recipient screening and management need to be developed.

Figure 1. Sites of infection among 20 lung transplant recipients who developed invasive infection from *Mycoplasma* or *Ureaplasma.**



*Patients with more than 1 site of infection were included in multiple categories.
BAL, bronchoalveolar lavage.

Figure 2. Clinical courses of 20 lung transplant recipients who developed invasive *Mycoplasma* or *Ureaplasma* infection from 2010-2019.



Disclosures: Rachel Miller, MD, Synexis: Research Grant.

1759. Incidence of Hospitalizations and Emergency Department Visits for Herpes Zoster in Immunocompromised and Immunocompetent Adults in Ontario, Canada, 2002–2016

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Background. Adults with immunocompromising conditions are at increased risk of herpes zoster (HZ) infection and related complications. We aimed to assess the incidence of HZ seen in hospital or emergency department in immunocompromised populations and compare it to that of immunocompetent populations.

Methods. Using healthcare administrative data, we calculated incidence rates (IR) of HZ in Ontario, Canada between April 1, 2002 and August 31, 2016 in adults ≥18 years categorized as immunocompromised or immunocompetent. We repeated these analyses by type of immunocompromising condition and provided incidence rate ratios (IRR) comparing to immunocompetent adults. We also calculated IRs and IRRs of HZ complications by immunocompromised status.