

Two months later the patient was re-admitted for *N. cyriacigeorgica* bacteremia and a pulmonary embolism. During his hospital stay, the patient had a STEMI, but due to multiple comorbidities did not undergo cardiac catheterization. The family elected to withdraw care, and the patient expired.

**Conclusion.** *N. cyriacigeorgica* is more commonly identified in brain abscesses or skin infections, in the setting of immunosuppression. We report here on an unusual case of *N. cyriacigeorgica* endocarditis in a patient with COPD. Other than COPD the patient had no known risk factors for *N. cyriacigeorgica*, including chronic steroid use.

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

#### 1085. Enterococcal Cardiac Implantable Electronic Device (CIED) Infections: Clinical Features and Outcomes

Timothy S. Oh, BS<sup>1</sup>; James E. Peacock Jr., MD<sup>1</sup>; Katherine Le, MD<sup>2</sup>; M Rizwan Sohail, MD<sup>3</sup>; Larry M. Baddour, MD<sup>2</sup>; Holenarasipur R. Vikram, MD<sup>3</sup>; Jose M Miro, MD, PhD<sup>4</sup>; Jordan M. Prutkin, MD, MHS<sup>5</sup>; Arnold J. Greenspon, MD<sup>6</sup>; Roger G Carrillo, MD<sup>7</sup>; Stephan B. Danik, MD<sup>8</sup>; Christoph K. Naber, MD, PhD<sup>9</sup>; Elisabeth Blank, MD<sup>9</sup>; Chi-Hong Tseng, PhD<sup>10</sup> and Daniel Z. Uslan, MD<sup>10</sup>; <sup>1</sup>Wake Forest School of Medicine, Winston-Salem, North Carolina, <sup>2</sup>Mayo Clinic College of Medicine, Rochester, Minnesota, <sup>3</sup>Mayo Clinic, Scottsdale, Arizona, <sup>4</sup>Hospital Clinic-IDIBAPS, Barcelona, Spain, <sup>5</sup>University of Washington, Seattle, Washington, <sup>6</sup>Thomas Jefferson University Hospital, Philadelphia, Pennsylvania, <sup>7</sup>Miller School of Medicine, Miami, Florida, <sup>8</sup>Harvard Medical School, Boston, Massachusetts, <sup>9</sup>Contilia Heart and Vascular Center, Essen, Germany, <sup>10</sup>David Geffen School of Medicine, Los Angeles, California

**Session:** 131. Bacteremia and Endocarditis

**Friday, October 5, 2018: 12:30 PM**

**Background.** Unlike enterococcal native and prosthetic valve infective endocarditis (IE), enterococcal CIED infections are not well described.

**Methods.** Data from the Multicenter Electrophysiologic Device Infection Collaboration (MEDIC), a prospective, observational, multinational cohort study of CIED infections, were used to provide a descriptive analysis of adult patients with CIED infections due to enterococcal species.

**Results.** Of 433 patients, 21 (4.8%) were diagnosed with enterococcal CIED infection. Specific data on enterococcal species and antimicrobial susceptibilities were not recorded. The mean age was 70.8 years. No patient had previous CIED infection. Twelve patients (57%) had permanent pacemakers, 5 (24%) had implantable cardioverter defibrillators, and 4 (19%) had biventricular devices. Among the 21 infections, 3 (14%) were categorized as CIED-related bloodstream infections and 18 (86%) as IE; no patient had isolated pocket infection. Of the IE cases, four were valvular IE, eight were lead IE, and six were both. Fourteen cases of IE (78%) were definite by the modified Duke criteria. Median time from last device procedure to infection was 510 days (range 37–2,952 days). The most common presenting symptom was fever (48%); five patients (24%) exhibited local signs of pocket infection. All 21 patients underwent TEE with vegetations demonstrated in 17 (81%). Blood cultures grew enterococci from all patients. The most common antimicrobial regimen was a penicillin plus aminoglycoside (38%); two patients (9.5%) received ampicillin + ceftriaxone. Antibiotics were given for a median of 43 days. Only 14 patients (67%) had complete device removal; the seven patients retaining their device were judged to be at high risk for extraction. There was one death during the index hospital stay with four additional patients dying over the 6 months after therapy (overall mortality 24%); two of the seven patients retaining their CIED died.

**Conclusion.** Enterococci caused 4.8% of all CIED infections in our cohort. Most infections appeared to be hematogenous in origin with late onset. IE was the most common infectious syndrome. A penicillin plus aminoglycoside, given for 6 weeks, was the most frequent therapy. Only 67% of patients underwent device removal. At 6 months follow-up, no relapses had occurred but overall mortality was 24%.

**Disclosures.** J. E. Peacock Jr., Pfizer, Inc.: Shareholder, Owns common stock in Pfizer which was inherited and held in a trust. M. R. Sohail, TyRx Inc.: Investigator, Research support. Medtronic Inc.: Investigator, Research support. Medtronic Inc.: Consultant, Speaker honorarium. Spectranetics: Consultant, Speaker honorarium. Boston Scientific Corp: Consultant, Speaker honorarium. L. M. Baddour, UpToDate: Collaborator, Royalty payment. J. M. Miro, Abbvie: Consultant and Grant Investigator, Consulting honoraria and Research grant. Bristol-Myers Squibb: Consultant and Grant Investigator, Consulting honoraria and Research grant. Genentech: Consultant and Grant Investigator, Consulting honoraria and Research grant. Medtronic: Consultant and Grant Investigator, Consulting honoraria and Research grant. Novartis: Consultant and Grant Investigator, Consulting honoraria and Research grant. Gilead Sciences: Consultant and Grant Investigator, Consulting honoraria and Research grant. Pfizer: Consultant and Grant Investigator, Consulting honoraria and Research grant. ViiV Healthcare: Consultant and Grant Investigator, Consulting honoraria and Research grant. A. J. Greenspon, Medtronic: Consultant, Speaker honorarium. Boston Scientific: Consultant, Speaker honorarium. St. Jude: Consultant, Speaker honorarium. R. G. Carrillo, St. Jude Medical Group: Speaker's Bureau, Research support. Spectranetics: Consultant, Speaker honorarium. Sorin Group: Speaker's Bureau, None. Boston Scientific Corp: Speaker's Bureau, None. D. Z. Uslan, Medtronic: Investigator, Research support. Boston Scientific: Consultant, Speaker honorarium.

#### 1086. Impact of Systematic Thoraco-Abdomino-Pelvic CT Scan on the Diagnosis of Infective Endocarditis

Raphaël Lecomte, PhD<sup>1</sup>; Nahema Issa, MD<sup>2</sup>; Paul Le Turnier, resident<sup>1</sup>; Benjamin Gaborit, MD<sup>3</sup>; Colin Deschamps, MD<sup>3</sup>; Nathalie Asseray, MD, PhD<sup>1</sup>; Fabrice Camou, MD<sup>2</sup> and David Boutoille, MD, PhD<sup>1</sup>; <sup>1</sup>Infectious Diseases, CHU – Hotel Dieu, Nantes, France, <sup>2</sup>Intensive Care and Infectious Disease Unit, Bordeaux University Hospital, Bordeaux, France

**Session:** 131. Bacteremia and Endocarditis

**Friday, October 5, 2018: 12:30 PM**

**Background.** The incidence of embolic events (EE) is high in patients with infective endocarditis (IE). EE influence patient management in different settings because they are minor criteria in the Duke classification and may lead to changes medical therapy or surgical strategy. If current guidelines suggest that systematic thoraco-abdominopelvic CT scan (TAP-CT) may be helpful, reliable data are lacking. The main objective of this study was to describe how systematic TAP-CT affects the diagnosis of patients with IE. Secondary objectives were to assess the impact of the TAP-CT on the management of patients with IE and the incidence of contrast-induced acute kidney injury (CI-AKI).

**Methods.** In this multicenter cohort study between January 2013 and July 2016, we included consecutive patients who had definite or possible acute IE according to the Duke-modified criteria, and after validation by the endocarditis teams. The main exclusion criterion was the absence of TAP-CT scan. We compared the Duke classification diagnosis data and treatment data (medical and/or surgical) regarding the presence or the absence of EE on the CT and investigated the tolerance of this examination as well.

**Results.** Of the 522 patients included in this study, 217 (41.6%) had one or more EE on the TAP-CT. The two major Duke modified criteria were found in 397 patients (76.1%) and 457 patients (87.6%) had a definite endocarditis. On the basis of TAP-CT results in asymptomatic patients, diagnostic classification was upgraded from possible endocarditis to definite endocarditis for only four cases which represent 0.8% of the population. The presence of EE on CT did not modify the duration of antibiotic treatment ( $P = 0.55$ ) and the decision of surgical treatment ( $P = 0.39$ ). Specific treatment of the EE was necessary in 42 patients (8.0%) but only nine of these EE (1.9%) were asymptomatic. CI-AKI was observed in 78 patients (14.9%).

**Conclusion.** The CT-scan findings slightly affected diagnosis of IE. The impact on the therapeutic management is low and the incidence of CI-AKI should not be underestimated. Additional studies are needed to assess whether CT-scan improves patient outcomes, leads to unnecessary procedures and increased costs.

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

#### 1087. Aortic Graft Infections Caused by *Propionibacterium acnes* at the Minneapolis Veterans Affairs Health Care System (MVAHCS) 2007–2017

Abdelghani El Rafei, MD<sup>1</sup> and Dimitri M. Drekonja, MD, MS, FIDSA<sup>1,2</sup>; <sup>1</sup>Internal Medicine, University of Minnesota, Minneapolis, Minnesota, <sup>2</sup>Department of Medicine, Infectious Diseases, Minneapolis Veterans Affairs Health Care System, Minneapolis, Minnesota

**Session:** 131. Bacteremia and Endocarditis

**Friday, October 5, 2018: 12:30 PM**

**Background.** *Propionibacterium acnes* is a Gram-positive microaerophilic bacterium and part of the human skin flora. The ability of *P. acnes* to cause infections has been recognized, particularly in the presence of hardware. We aimed to define the frequency of *P. acnes* infections, with a focus on aortic graft infection.

**Methods.** We used microbiology laboratory records at the Minneapolis Veterans Affairs Health Care System to identify all *P. acnes* cultures from January 2007 to January 2017. We retrospectively reviewed all adult ( $\geq 18$  years) patient's medical records to identify associated infectious syndromes. Case definitions by the management of Aortic Graft Infection Collaboration were used to classify aortic graft infection cases.

**Results.** We identified 328 positive *P. acnes* cultures during the study period. *P. acnes* was classified as a pathogen in 48 (15%), a pathogen of undetermined significance in 70 (21%), and a contaminant in 210 (64%) cases. We identified three cases aortic graft infection which accounted for (2.5%) of infections caused by *P. acnes*. Median age (range) at presentation was 74 years (67–83). Symptoms included pain ( $n = 3$ ), fever ( $n = 2$ ), and altered mental status ( $n = 1$ ). None were hypotensive. All patients had at least one revision for endoleak prior to presentation. Median time from symptom onset to diagnosis was 120 days (78–140). Microbiological diagnosis was obtained by blood cultures, percutaneous peri-graft tissue aspiration, and operative culture in each patient, respectively. Infection was complicated by metastatic abscess in one patient. All cultures grew on Day 7. All patients were treated with IV ceftriaxone, and two were transitioned to life-long oral suppressive antibiotic therapy. Two patients had complete removal of infected material. No relapse was documented and survival was 100% at 1 year follow-up.

**Conclusion.** Aortic graft infection is an uncommon subset of infections caused by *P. acnes*. Clinical course is indolent and diagnosis is delayed due to nonspecific clinical presentation. In contrast to endovascular graft infection caused by other organisms, mortality is low when treated with appropriate antibiotic therapy and removal of infected material. The current laboratory practice of holding blood cultures for 5 days may need to be altered when *P. acnes* is a potential cause of infection.

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

#### 1088. Ultrasensitive Detection of *C. difficile* Toxins in Stool Using Single Molecule Counting Technology: A Multicenter Study for Evaluation of Clinical Performance

Stephen Young, PhD<sup>1</sup>; Ray Mills, MS<sup>2</sup>; Christen Griego-Fullbright, MS<sup>2</sup>; Aaron Wagner, MS<sup>2</sup>; Emily Herding, MS<sup>3</sup>; Vickie Nordberg, MS<sup>4</sup>; Emily Friedland, PhD<sup>5</sup>; Amelita Bartolome, PhD<sup>5</sup>; Anna Almazan, BS<sup>2</sup>; Stanley Tam, MS<sup>5</sup>; Sheryl Bischoch, MS<sup>5</sup>; Salina Abusali, MS<sup>5</sup>; Johanna Sandlund, MD, PhD<sup>5</sup>; Joel Estis, MS<sup>5</sup>; Jeffrey Bishop, PhD<sup>5</sup> and Glen Hansen, PhD<sup>4</sup>; <sup>1</sup>Research and Clinical Trials, TriCore Reference Laboratories, Albuquerque, New Mexico, <sup>2</sup>TriCore Reference Laboratories, Albuquerque, New Mexico, <sup>3</sup>Minneapolis Medical Research Foundation, Hennepin County Medical Center, Minneapolis, Minnesota,