Results. A total of 260 patients (mean age 55 ± 17 years; 37.5% female) presented to the EC 363 times. Eighty-four percent of patients had neutropenia >7 days in duration and the median ANC at presentation was 0 cells/mm^3 (range: 0–490 cells/mm^3). The majority of patients had acute myeloid leukemia (64%) and 50% had relapsed disease. Fifty-eight of 363 (16%) presented with PNA, 34/363 (9.3%) with SSTI, 12/363 (3.3%) with UTI, 11/363 (3 %) with IAI, and 7/363 (2%) with sinusitis. Among patients directly admitted to the ICU, PNA occurred in 3/22 (14%). Five of 7 patients (71%) who were subsequently transferred to the ICU had PNA. PNA was more common in patients who died in hospital vs. those who survived (9/20 [45%] vs. 47/324 [15%], P < 0.01) and 9/56 (16%) of patients with PNA died in hospital.

Conclusion. PNA was the most common diagnosis in leukemia patients presenting to the EC with NF and was associated with high morbidity and mortality. These data highlight PNA as a target for further investigation in this population with regards to the role of timely diagnosis and treatment.

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2356. Lymphopenia after Radiotherapy and Risk of Infection

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Background. Radiotherapy may cause lymphocyte depletion; although extent, duration, and possible associated excess risk of infection from lymphopenia are unknown. These questions were addressed in a recently established cohort of consecutive cancer patients undergoing radiotherapy and with complete long-term nationwide follow-up.

Methods. The cohort constitutes patients who received first course of radiotherapy in the period 2005–2016 at Copenhagen University Hospital. Lymphocyte counts at radiotherapy start and at 1, 6, 12 and 24 months thereafter allowed for classifying those with lymphopenia (<1.0 × 10^3 cells/μL). Whether this condition was associated with excess risk of subsequent first hospital admission with a diagnosis of infection was assessed by Poisson regression analysis, adjusted for age, sex, and calendar year.

Results. During the study period 22,151 patients had a first course of radiotherapy, of whom 14,823 had a lymphocyte count, measured in at least one of the pre-defined time points. Median duration of radiotherapy was 28 days (IQR, 12–39). Lymphocyte counts declined in the first month after initiation of radiotherapy then increased gradually during follow-up. At month 24, 28.6% of cohort in follow-up had lymphopenia (Figure 1). During 39,620 per 1,000 person-years of follow-up, 3,644 (24.6%) patients had a hospital admission with an infection; most frequently a respiratory infection (48.2%), followed by urinary tract (13.8%) and gastrointestinal infections (8.5%). Lymphopenia at 0, 6, 12 and 24 months after radiotherapy start, but not at month 1, was associated with increased risk of subsequent admission with infection (Table 1).

Conclusion. The majority of cancer patients develop lymphopenia after radiotherapy, which persist in a fraction of the population for several months. Radiotherapy-associated lymphopenia was associated with increased risk of subsequent hospital admission with an infection, suggesting clinically relevant impairment of immune function in a subgroup of the treated population.

Figure 1. Lymphocyte Counts Before and After Radiotherapy Start

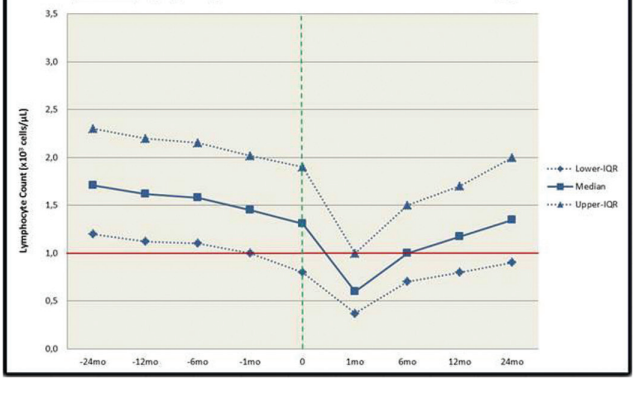

Table 1. Lymphopenia and Subsequent Risk of Infection.

Time since radiotherapy start (Months)	Available Lymphocyte Count n (%)	Lymphocyte Count <1.0 x 10^3 cells/μL n (%)	IR per 1,000 PY (95% CI) Lymphocyte Count		aIRR (95% CI) Lymphopenia vs No Lymphopenia
			<1.0 x 10^3 cells/μL	≥1.0 x 10^3 cells/μL	
0	6 202 (41.8)	1 986 (32.0)	158.8 (147.0-171.6)	98.4 (92.4-104.8)	1.8 (1.7-2.0)
1	6 145 (41.5)	4 496 (73.2)	108.0 (101.9-114.5)	127.8 (116.1-140.7)	1.0 (0.9-1.1)
6	3 811 (25.7)	1 733 (45.5)	112.6 (100.6-125.9)	95.6 (86.8-105.2)	1.2 (1.1-1.4)
12	2 551 (17.2)	976 (38.3)	116.4 (100.0-135.4)	85.4 (76.3-95.7)	1.3 (1.1-1.6)
24	1 637 (11.0)	468 (28.6)	176.3 (144.0-215.8)	68.5 (58.8-79.8)	2.4 (1.8-3.1)

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

2357. *Trypanozoma cruzi* Infection in Patients Undergoing Solid Organ Transplantation

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Background. It is estimated that 1.5 million people are infected with *T. cruzi* in Argentina (4%). Chagas reactivation rate (R) in patients with solid organ transplantation (SOT) is around 33%, being higher in cardiac transplantation (Tx).

Objective: To describe the clinical characteristics, evolution, mortality, to evaluate reactivation risk factors and to analyze the usefulness of molecular tests in patients undergoing at SOT with Chagas' disease risk (ChR) (R or Donor-derived transmission, -DT-), in a hospital in our country.

Methods. Retrospective cohort from all the patients who received an SOT in our hospital from January 1988 to March 2017. All patients with ChR: either R or DT were analyzed. Inclusion: survival more 30 days and 6 months of follow-up or until death. We performed post-Tx monitoring with parasitaemia (Strout), and serial whole blood polymerase chain reaction (PCR) testing, weekly until 2 months, every 2 weeks until the sixth month and monthly until the year, later annual. PCR monitoring is done since 2006.

Results. We performed 1932 SOT in 29 years: 54 SOT in patients with ChR, 46 chagasic recipients (CR) and 8 chagasic donors (CD) to negative recipient 24/46 (52%) presented R, (see Table 1), 4 had more than one episode. Time to first R was 67 days (r = 3–296, median 30 days). At the time of the R Strout was performed in 19 episode 13 were negative, PCR was positive in 10/10 of perfcormed test, 32% vs. 100% (P = 0.001). Clinical R: 5 episode in 4 patients (panniculitis 3, 1 with myocarditis, 1 myocarditis). Strout was negative in 2 of these, in the other episode monitoring had not been performed. Immunosuppression (IS): there were no differences in the IS, (induction and treatment of rejections). Reactivation: 21/24 responded to treatment, 2 spontaneously PCR-negative, 1 died. Mortality: 6/24 (25%) in pt. R and 2/17 (12%) in pt no R (P = ns), not related mortality. DT occurred in 1/ 3 liver and in 0/5 renal recipients.

Type of Tx	All	Reactivation	Clinic
Liver (L)	786	7/26 (27%)	1/7 (14%)
Heart	241	13/23 (56%)	2/13 (15%)
Kidney (K)	613	2/5 (40%)	1/2 (50%)
Lung	105	1/2 (50%)	0
LK	26	1/1 (100%	0
Others	161	0	0

Conclusion. PCR was more sensitive than Strout for detection of R or transmission. There was no clinical R in pt monitored by PCR. Also PCR sensitivity allow safe acceptance of Chagasic organs.

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

2358. Infection Risk Associated with Daratumumab

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