of the T2 and BC in Tx and non-Tx patients were compared. BC obtained within 7 days before or after the T2 test were included in the analysis. TAT, sensitivity, specificity, PPV and NPV were calculated using positive BC as the standard. Differences between groups were assessed using two sample proportions testing at $\alpha = 0.05$.

Results. A total of 1,272 patients with suspected candidemia had T2 done: 1,162 (91%) non-Tx and 110 (9%) Tx patients. Average TAT for T2 was 13 hours (5–41) vs. 34 hours (21–109) to initial positive BC result and 4 days (3–13) to species-specific BC result. In four non-Tx patients with negative T2, *C. lusitaniae*, *C. dubliniensis*, and *C. kefyr* were isolated in BC. Performance characteristics of T2 and BC in the two groups is shown (Table 1). Of the T2+/BC– cases (n = 102), 9% had retinitis and 9% had invasive candidiasis.

Conclusion. The rapid TAT, good sensitivity, and high NPV of T2 in Tx patients has clinical implications and can help support antifungal stewardship efforts in this population. The clinical significance of T2 positivity in the presence of negative BC needs further investigation.

Table1: Performance Characteristics of T2 Compared with BC (N = 1,272)

	Tx (n = 110)	Non-Tx (n = 1162)	P-value
T2 + and blood culture +	5 (4.5%)	35 (3.01%)	0.3917
T2 + and blood culture –	19 (17.3%)	86 (7.4%)	0.0003
T2 - and blood culture +	1 (0.9%)	41 (3.5%)	0.1431
Sensitivity	83.3%	46.1%	
Specificity	81.9%	92.4%	
PPV	20.8%	28.9%	
NPV	98.8%	96.2%	

Disclosures. **G. Alangaden**, T2 Biosystems: Speaker's Bureau, Educational grant and Speaker honorarium.

1135. Strongyloides Stercolaris Serology in Transplant Patients: To Test or Not?

Karla Rivera Rivera, MD[1]; Tulsi Shah, MBBS[2]; Julia Garcia-Diaz, MD, FIDSA[2] and Jonathan Hand, MD[2]; [1]Infectious Diseases, Ochsner Clinic Foundation, Covington, Louisiana, [2]Infectious Diseases, Ochsner Clinic Foundation, New Orleans, Louisiana

Session: 134. Fungi and Parasites in Immunocompromised Patients
Friday, October 5, 2018: 12:30 PM

Background. *Strongyloides stercoralis* is an intestinal nematode endemic to the tropics, subtropics, and to a limited extent the United States and Europe. The global estimates of strongyloidiasis are reported to range from 3 to 100 million infected worldwide; however, the true US prevalence is unclear. The seroprevalence of infection in solid-organ transplant candidates and recipients in the New Orleans, Louisiana region is also unknown. The purpose of this study was to identify the prevalence of *Strongyloides* seropositivity within transplant candidates at Ochsner Medical Center (OMC).

Methods. Patients were identified using EPIC-CLARITY with ICD-9 and ICD-10 codes for any solid-organ transplant at OMC from July 2012 to December 2016. Inclusion criteria were age 18 or older, patients evaluated for solid-organ transplant, and *Strongyloides* IgG testing. Patients were excluded if they had other immunocompromising conditions or exposures including but not limited to steroids, TNF-alpha, or biologic agent use. The primary outcome was the overall prevalence rate of strongyloidiasis at OMC. Secondary outcome was the comparison of prevalence between January 1, 2012 to July 31, 2016 (when testing was ordered based on risk stratification) vs. August 1, 2016 to December 31, 2016 (when routine testing was implemented).

Results. We analyzed a total of 1,047 patients which had 1,128 tests ordered for S*trongyloides*. Of those, 985 were unique patients (62 patients had multiple serological tests resulting in 81 repeat tests). During July 1, 2012 to July 31, 2016 testing yielded a total of 822 tests. From August 1, 2016 to December 31, 2016 testing yielded 306 tests.

Overall, 43/1,128 (3.8%) tests were positive for *Strongyloides*. The remaining 1,085/1,128 (96.2%) tested negative. For our secondary outcome, we found that testing based on risk stratification yielded 22/822 (2.7%) positives while testing for all patients we had 21/306 (6.9%) positives.

Conclusion. Our data suggest that testing based on risk stratification yielded a lower prevalence rate as compared with generalized testing, underestimating the true incidence of disease (2.7% vs. 6.9%). Testing all patients being evaluated for transplantation will capture a greater number of patients with positive serology.

Disclosures. **J. Garcia-Diaz**, Astellas Pharma: Speaker's Bureau, Speaker honorarium.

1136. Universal Prophylaxis for Prevention of Invasive Aspergillus in Lung Transplant Recipients

Alexis Guenette, DO[1]; A Adrian Gonzalez, MD[2] and Amir Emtiazjoo, MD[3]; [1]Division of Infectious Disease, University of Florida, Gainesville, Florida, [2]Infectious Disease, University of Florida, Gainesvile, Florida, [3]Division of Pulmonary Disease and Critical Medicine, University of Florida, Gainesville, Florida

Session: 134. Fungi and Parasites in Immunocompromised Patients
Friday, October 5, 2018: 12:30 PM

Background. Invasive aspergillosis (IA) is a significant complication status post lung transplantation with an incidence of 6% to 16%. Because early diagnosis of IA in lung transplant is hampered by the lack of specific clinical signs and by the low sensitivity of culture-based diagnostic methods, the efficacy of bronchoalveolar lavage galactomannan (BAL GM) for early diagnosis is explored in this study.

Methods. A retrospective analysis was performed on 45 consecutive lung transplant recipients between January 2015 and February 2016 at UF Health Shands Hospital. All patients were placed on prophylactic itraconazole post-transplant. Surveillance bronchoscopies were performed at 2 weeks, 1 month, 3 months, 6 months, 9 months, and 12 months post-transplant. During each bronchoscopy, bacterial, fungal, and acid-fast bacterial cultures along with BAL GM [an optical density (OD) index of ≥0.5 considered positive] were obtained. If BAL GM ≥1.0, the patient was switched to voriconazole for further treatment. CT Chest was also evaluated. If BAL GM remained ≤1.0 at the 6 month interval, then prophylaxis was complete. IA was defined using the EORTC/MSG criteria for invasive fungal disease (i.e., patient classified as either having proven, probable or possible IA).

Results. There was a total of 225 observations from the 45 patients. Two patients (4.4%) had proven IA with a mean GM of 4.153 (SE, 0.629) and seven patients (15%) had probable IA with a mean of 2.169 (SE, 0.409). There was no correlation of cold ischemic time (P = 0.88), primary graft dysfunction (PGD, P = 0.38), presence of Candida species (P =0.048) or non-tuberculous mycobacteria (NTM) in bronchoalveolar lavage (P = 0.044), and viral pneumonitis (P = 0.047) with a positive BAL GM. All nine patients with GM >1 were switched to voriconazole from itraconazole which resulted in negative GM levels on follow-up bronchoscopy.

Conclusion. Our data suggest that the implementation of universal antifungal prophylaxis with itraconazole may not be efficacious in preventing IA in lung transplant recipients. On the other hand, surveillance with BAL GM is a strategy that can lead to early detection of IA in patients during the first year after lung transplantation.

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

1137. Implementation of Universal Screening for Strongyloidiasis Among Solid-Organ and Hematopoietic Stem Cell Transplantation Candidates in a Non-endemic Area

Angelica Kottkamp, MD[1] and Sapna Mehta, MD[2]; [1]Department of Medicine, NYU School of Medicine, New York, New York, [2]NYU Transplant Institute, New York, New York

Session: 134. Fungi and Parasites in Immunocompromised Patients
Friday, October 5, 2018: 12:30 PM

Background. Strongyloidiasis can lead to hyperinfection and dissemination after transplantation with significant morbidity and mortality. Treatment for Strongyloidiasis prior to transplantation can reduce the risk of disseminated infection. Targeted screening based on travel history and country of origin incompletely identifies at-risk patients. Data on universal screening prior to solid-organ (SOT) or hematopoietic stem cell transplantation (HSCT) are limited. We implemented universal serology-based screening for strongyloides at our transplant center, located in a metropolitan non-ndemic area.

Methods. We identified patients screened with serum Strongyloides IgG by ELISA during pre-transplant evaluation for SOT or HSCT from August 1, 2017 to April 25, 2018. We reviewed adherence to the screening recommendation by program type and the medical record of seropositive patients for country of origin, history of eosinophilia (>500 cell/μL), Gram-negative bacteremia, ova and parasite (O&P) examination and treatment.

Results. A total of 812 patients were evaluated for transplant during the study period: 484 for kidney, 152 for liver, 12 for liver/kidney transplant, 40 for heart, 24 for lung, and 100 for HSCT. 201 (24.7%) of the 812 patients were screened for Strongyloides; 107 (17%) evaluated for abdominal transplant, 32 (50%) for thoracic transplant, and 62 (60%) for HSCT. Seventeen (8.4%) of 201 patients screened tested positive: nine evaluated for kidney transplant, four for heart, one for liver, and three for HSCT. Nine of 17 patients (53%) were treated with Ivermectin or referred to Infectious Diseases clinic prior to our review. Ten (59%) seropositive patients were from the United States and 70% had no documented travel to endemic areas; six patients were from countries other than the United States; and one from Puerto Rico. Two patients with Strongyloidiasis had eosinophilia, one had history of *Klebsiella pneumoniae* bacteremia and one had stool O&P examination. Screening was higher when using an electronic order set (57% vs. 17%).

Conclusion. Universal screening for Strongyloidiasis identified individuals with latent infection who did not have epidemiological or clinical findings suggestive of Strongyloidiasis. Screening for Strongyloidiasis was higher in transplant programs that incorporated the recommendation into an electronic order set.

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

1138. Retrospective Cohort Analysis of Amphotericin B Nephrotoxicity in Kidney Transplant Recipients

Mariam Assi, MD[1]; Dominic Engracia, BS[2]; Idris Yakubu, PharmD[3]; Gaurav Gupta, MD[4]; Nargiza Kurbanova, RN, BSN, BA[3] and Oveimar De La Cruz, MD[5]; [1]Internal Medicine, Virginia Commonwealth University Health System, Richmond, Virginia, [2]School of Medicine, Virginia Commonwealth University, Richmond, Virginia, [3]Virginia Commonwealth University Health System, Richmond, Virginia, [4]Nephrology, Virginia Commonwealth University Health System, Richmond, Virginia, [5]Infectious Diseases, Virginia Commonwealth University Health System, Richmond, Virginia

Session: 134. Fungi and Parasites in Immunocompromised Patients
Friday, October 5, 2018: 12:30 PM