lesion and 86.2% had ≤ 3 lesions with a median = 2 cm (IQR 1–2). Lesions presented predominantly on upper limbs (40.9%), followed by lower limbs (23.2%). According to PAHO and WHO criteria, 18% (12.3% adult vs. 19.3%, $P = 0.007$) and 44.4% (adolescents 42% vs. adults 43%, $P = 0.45$), respectively, were eligible for local therapies.

Conclusion. Local therapies have feasible use in this population with mild and uncomplicated clinical presentation; however, its applicability is limited to current management criteria. Individualized risk-–benefit assessment may increase eligibility.

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292. Systemic Cat Scratch Disease in Immunocompetent Adults: A Retrospective Case Series

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Session: 49. Global Health Potpourri

Thursday, October 5, 2017: 12:30 PM

Background. Cat-scratch disease (CSD) has worldwide distribution and is the most frequent presentation of Bartonella henselae infection. Systemic CSD has mainly been reported in immunocompetent children and immunosuppressed adults. The aim of this study was to assess the clinical and laboratory findings of systemic CSD in immunocompetent adults.

Methods. A retrospective, cohort study of all consecutive, immunocompetent adult patients diagnosed with systemic CSD in 10-year period (2007–2016), was conducted at the University Hospital for Infectious Diseases Zagreb. Diagnosis was established by serology (IgM > 1:20, IgG > 1:256 or the fourfold rise in IgG titer in the convalescent phase) or polymerase chain reaction (PCR).

Results. In total, 32 cases were identified, 23 males, mean age of 35 ± 16 years, and majority of them (96.9%) recalled cat exposure. Twenty-one patients (65.6%) presented as fever of unknown origin, nine (28.1%) with hepatosplenic form, one patient with oculoglandular with prolonged fever and one with parotitis. Thirty-one (96.9%) patients were febrile for the 8.4 ± 5.6 days before hospitalization. Only 18.8% had concomitant lymphadenitis, 59.4% had headache, 28.1% abdominal pain and respiratory symptoms, 37.5% hepatomegaly and 31.3% splenomegaly on clinical examination. All except one patient had elevated CRP (70.8 ± 46.9), 12 patients (37.5%) had elevated WBC, 7 patients (21.8%) had elevated aminotranspherases, and 4 patients (12.5%) had multiple spleen abscesses. The diagnosis was established after 5.2 ± 5.3 days of hospitalization. Thirty (93.7%) received antibiotic treatment for the mean duration of 11.4 ± 5.2 days (18 (56.2%) macrolides (3 in monotherapy), 16 (50%) β-lactams (in combination), three (9.37%) doxycycline monotherapy, five (15.6%) fluoroquinolones (2 in monotherapy), four (12.5%) rifampicin, and five (15.6%) gentamicin always in combination). The mean duration of fever on antibiotic therapy was 7.3 ± 5.8 days. All patients were cured without sequelae regardless of treatment.

Conclusion. Systemic CSD is not rare in healthy individuals. Since the diversity of the clinical manifestations in adults may be misleading, the infection should be suspected in patients with recent contact with a cat even despite the presence of lymphadenopathy.

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293. What Is Different When Dealing with Bacteremic Brucellosis?

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Background. Bacteremic brucellosis is an acute febrile disease often associated with digestive complaints and biological inflammatory syndrome. In this perspective, our study aimed to determine predictive factors of bacteremia in patients with brucellosis.

Methods. We conducted a retrospective study including all patients hospitalized with brucellosis between 1990 and 2014.

Results. We included 161 cases of brucellosis among which bacteremia was documented in 30 cases (18.6%). Mean age was of 39.6 ± 17 years. *Brucella melitensis* was solely isolated. In bacteremic brucellosis, there were more fever (93.3% vs. 78%; $P = 0.049$; HR=4), nausea (16.7% vs. 4.6%; $P = 0.033$; HR = 4.2), and splenomegaly (20% vs. 7.6%; $P = 0.049$; HR = 3). The acute form was significantly more common in bacteremic brucellosis (66.7% vs. 42%; $P = 0.015$; HR = 2.7). Bacteremic brucellosis patients had a significantly higher frequence of anemia (76.7% vs. 51.6%; $P = 0.013$; HR=3.2) and higher C-reactive protein value (85.5 ± 45 vs. 35 ± 20 mg/L; $P < 0.001$). Commonly used antimicrobial regimens consisted of rifampicin plus doxycycline given for 6 weeks in both bacteremic and non-bacteremic brucellosis (86.7% vs. 72%; $P = 0.1$). A favorable outcome was significantly associated with bacteremic brucellosis (73.3% vs. 52%; $P = 0.03$; HR=2.38). Multivariate analysis using logistic regression revealed that the presence of nausea (HR = 9; CI95% 14–60; $P = 0.002$), acute form of brucellosis (HR = 4.5; CI95% 1.2–17; $P = 0.025$) and C-reactive protein value (HR = 1.12; CI95% 1.1–1.2; $P = 0.02$) were independent predictors of bacteremic brucellosis.

Conclusion. Our study highlighted clinical and biological particularities of bacteremic brucellosis which may help clinicians to establish a prompt diagnosis and suitable treatment, two main conditions to improve patients' prognosis.

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

294. Follow-up Evaluation of Air Force Blood Donors Screening Positive for Chagas Disease

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Background. Chagas disease, caused by the protozoan parasite *Trypanosoma cruzi*, is endemic to Texas and has significant morbidity associated with its cardiac pathology. The Joint Base San Antonio-Lackland (JBSA) represents a healthcare system with universal coverage to its beneficiaries and its blood bank screens all first-time blood donors for *T. cruzi* infection. Although there is a published, standardized approach for diagnosis and evaluation of Chagas disease in the United States, adherence to this approach has not been studied.

Methods. A retrospective chart review was performed on all persons who screened positive for *T. cruzi* on blood donation at JBSA from 2014 to 2016. Charts were reviewed to determine frequency and results of confirmatory testing, history and physical, EKG, and 30 second rhythm strip; outcomes of these evaluations were ascertained. Chagas disease was considered confirmed on the basis of positive EIA and TESA testing from the CDC and/or two different positive serologic tests.

Results. Of the 43,402 blood donors at JBSA, 23 screened positive for Chagas disease. Follow-up information was available on 22 (95.7%). Seventeen (77%) were military trainees and 18 (82%) were male. Patients had a mean of 2.5 (range 1–5) additional serologic tests, with 13 different combinations of confirmatory tests ordered, including 17 (77%) who had the initial screening test repeated. Two patients (9%), both from Texas, met criteria for Chagas disease. One of these was diagnosed with cardiomyopathy and underwent administrative separation from the Air Force. Eleven (50%) had Chagas disease excluded on the basis of two negative follow-up tests, and 9 (41%) had one negative follow-up test. All underwent history and physical, 15 (68%) had an EKG, and 5 (22%) had a 30 second rhythm strip. Fourteen (64%) were referred to infectious diseases.

Conclusion. Among a small cohort of active duty service members who screened positive for *T. cruzi* infection on blood donation, diagnostic workup, and evaluation varied considerably, despite universal access to no-cost medical care within a single system. Opportunities exist within the military health system to decrease heterogeneity and to improve evaluation of persons who screen positive in the future.

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295. Primary Care-Based Screening for *Trypanosoma cruzi* in High-Risk Populations: Results of the Strong Hearts Pilot in East Boston, Massachusetts

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Background. More than 300,000 people in the United States may be infected with Trypanosoma cruzi. This study describes the results of the Strong Hearts pilot project to integrate screening and facilitate referral for treatment for T. cruzi infection into primary care settings serving patients at high risk in Massachusetts.

Methods. We partnered with the Medicine, Pediatrics, Obstetrics, and Family Medicine divisions at the East Boston Neighborhood Health Center. Continuing education about Chagas disease was offered to healthcare providers, and community outreach to educate at-risk individuals and families was initiated. One-time screening for all patients under 50 years of age who lived in Mexico, South or Central America for at least 6 months was recommended. The initial screening test was an ELISA performed by a commercial laboratory. Confirmatory testing was performed at the Centers for Disease Control and Prevention (CDC) using serum saved at the health center laboratory. Patients with two positive tests were referred to the Infectious Disease Department of a partner institution for further evaluation and treatment.

Results. Three screening tests were ordered at the health center in the 3 months before the pilot. During the first 6 weeks of the pilot, participating providers ordered 203 screening tests. The patients screened included 90 (44%) women and 113 (56%) men; 90 (44%) were from El Salvador and 46 (23%) from Colombia. Thus far, results are available for 123 tests, among which 118 are negative and five are positive (one confirmed positive, one confirmed negative, and three pending). Two patients have been referred and seen by the partnering ID clinic, both within 6 weeks of the initial screening test.

Conclusion. The burden of Chagas disease may be underappreciated even in facilities that serve high-risk patients. Our preliminary findings suggest that primary care-based screening for Chagas disease is feasible and embraced by providers and patients, in the context of appropriate education and a seamless system for referral and treatment.

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