Deptartment of Public Health; Massimo Pacilli, Chicago Department of Public Health

Background: *Candida auris* and carbapenemase-producing organisms (CPO) are multidrug-resistant organisms that can colonize people for prolonged periods and can cause invasive infections and spread in healthcare settings, particularly in high-acuity long-term care facilities. Point-prevalence surveys (PPSs) conducted in long-term acute-care hospitals in the Chicago region identified median prevalence of colonization to be 31% for *C. auris* and 24% for CPO. Prevalence of *C. auris* colonization has not been described in pediatric populations in the United States, and limited data exist on CPO colonization in children outside intensive care units. The Chicago Department of Public Health (CDPH) conducted a PPS to assess *C. auris* and CPO colonization in a pediatric hospital serving high-acuity patients with extended lengths of stay (LOS). **Methods:** CDPH conducted a PPS in August 2019 in a pediatric hospital with extended LOS to screen for *C. auris* and CPO colonization. Medical devices (ie, gastrostomy tubes, tracheostomies, mechanical ventilators, and central venous catheters [CVC]) and LOS were documented. Screening specimens consisted of composite bilateral axillae and groin swabs for *C. auris* and rectal swabs for CPO testing. The Wisconsin State Laboratory of Hygiene tested all specimens. Real-time polymerase chain reaction (PCR) assays were used to detect *C. auris* DNA and carbapenemase genes: *bla*KPC, *bla*NDM, *bla*VIM, *bla*OXA-48, and *bla*IMP (Xpert Carba-R Assay, Cepheid, Sunnyvale, CA). All axillae and groin swabs were processed by PCR and culture to identify *C. auris*. For CPO, culture was only performed on PCR-positive specimens. **Results:** Of the 29 patients hospitalized, 26 (90%) had gastrostomy tubes, 24 (83%) had tracheostomies, 20 (69%) required mechanical ventilation, and 3 (10%) had CVCs. Also, 25 (86%) were screened for *C. auris* and CPO; 4 (14%) lacked parental consent and were not swabbed. Two rectal specimens were unsatisfactory, producing invalid CPO test results. Median LOS was 35 days (range, 1–300 days). No patients were positive for *C. auris*. From CPO screening, *bla*OXA-48 was detected in 1 patient sample, yielding a CPO prevalence of 3.4% (1 of 29). No organism was recovered from the *bla*OXA-48 positive specimen. **Conclusions:** This is the first documented screening of *C. auris* colonization in a pediatric hospital with extended LOS. Despite a high prevalence of *C. auris* and CPOs in adult healthcare settings of similar acuity in the region, *C. auris* was not identified and CPOs were rare at this pediatric facility. Additional evaluations in pediatric hospitals should be conducted to further understand *C. auris* and CPO prevalence in this population.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.662

Presentation Type:
Poster Presentation

***Candida auris* in the US Department of Veterans' Affairs (VA)**

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Background: *Candida auris* is an emerging pathogen with high mortality and challenges in detection. *C. auris* healthcare-associated infections are now being reported worldwide. Most isolates are resistant to fluconazole, and some show resistance to all 3 classes of antifungals. Herein, we describe *C. auris* surveillance in the VA. **Methods:** Cultures were identified using VA data sources for *C. auris* isolates and surveillance cultures (axilla and groin) performed January 1, 2010, through October 15, 2019. Chart reviews were performed for patients with *C. auris*, including isolate susceptibilities and antifungal treatment. **Results:** Overall, 6 *C. auris* isolates from 3 patients at 2 VA hospitals (located in the Midwest and Northeast) were identified. From a single patient, 3 urine isolates were identified June–July 2018, and they were susceptible to all antifungals tested (voriconazole, posaconazole, micafungin, itraconazole, flucytosine, caspofungin, anidulafungin, amphotericin B, and fluconazole). No antifungal treatment was received (presumed colonization). *C. auris* surveillance cultures for 32 additional patients at this facility between July 10, 2018, and July 19, 2018, were negative. From a second patient (admitted November 9, 2018), 2 *C. auris* blood isolates were identified at the same facility, first on February 3, 2019, and they were susceptible to all antifungals tested (same as above). The infection was deemed healthcare associated, and the patient received 2 weeks of micafungin. On October 11, 2019, *C. auris* was identified again (susceptibilities as above) and another course of micafungin was started. A third patient from a different VA hospital had a *C. auris* sputum isolate (September 5, 2018, susceptibilities not reported), which was not treated with antifungals. This patient with tracheostomy had a documented history of *C. auris* colonization from a non-VA long-term care facility. This VA facility screened 3 additional patients for "rule out *C. auris*" between July 2018 and March 2019, finalized as *C. parapsilosis* (1 blood and 1 wound isolate) and *C. tropicalis* (1 blood isolate). At 2 other VA facilities, 3 patients had *C. auris* surveillance cultures performed in 2019, which were negative. Additionally, at least 65 isolates of *C. haemulonii*, which can be difficult to distinguish from *C. auris*, have been identified from 51 unique individuals at 24 other VA facilities since 2010. **Conclusions:** Two VA facilities have identified cases of *C. auris* infection and colonization. Additional awareness is needed because *C. auris* can be difficult to identify using traditional biochemical methods and may be resistant to standard treatment. According to the CDC, screening of close healthcare contacts should be considered for patients with newly identified *C. auris* infection or colonization. Early and accurate diagnosis are important for improving outcomes and reducing transmission of this rapidly emerging pathogen.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.663

Presentation Type:
Poster Presentation

***Candida auris* Infection Among Patients With Cancer in an Oncology Center in Eastern India**

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Background: The multidrug-resistant fungus *Candida auris* is emerging as a major cause of healthcare-associated infection

globally. Understanding the epidemiology of these infections in vulnerable groups such as cancer patients is important for hospital infection control and their effective management. In this report we present diagnostic, clinical, antifungal resistance and outcome data of 11 cases of *C. auris* infection from an oncology center in India. **Methods:** *C. auris* strains were identified by Sanger-based DNA sequencing of the internal transcriber spacer (ITS) gene. Antifungal susceptibility testing (AFST) was performed using the broth dilution method. Identification and AFST were checked by the WHO Collaborating Center for Reference & Research on Fungi of Medical Importance. Patients had both empirical as well as directed therapy with antifungal agents based on AFST results and clinical assessment. **Results:** Between November 2018 and March 2019, 11 cases of *C. auris* (8 from patients with solid-organ tumors and 3 from hematological malignancy) were detected. Two distinct genetic clusters were identified by ITS gene sequencing; one of these clusters showed 100% homology with a previously unknown *C. auris* isolate (GenBank accession no. MK881076) and the other cluster had a 100% identity score with isolates from Japan and South Korea (GenBank accession nos. MH071441, KY657027, and EU884189). All 11 strains were resistant to fluconazole. With voriconazole, 1 isolate was susceptible, 3 were resistant, and 7 showed dose-dependent susceptibility. Two isolates were resistant to amphotericin B. Resistance to caspofungin or anidulafungin was noted in 1 of 11 isolates (9%); most showed intermediate susceptibility (63% to caspofungin). Among all of the patients, 72% were from the intensive care unit (ICU) or the high-dependency unit. The 30-day all-cause mortality was 5 of 11 (45%) in the *C. auris* group and 4 of 11 (36%) the control group (ie, infections with other *Candida* spp during same period). Duration of ICU stay in the *C. auris* group was 12 days and in the control group it was 6 days. The median cost (in terms of hospital bill at the time of discharge or death) for management of *Candida auris* infection and the primary medical condition was US$10,121 for the *C. auris* groups and US$8,608 for the control group. Most cases (10 of 11) were detected in wards without isolation rooms, and 8 of the 11 *C. auris* cases (73%) were detected in patients in the intensive care unit. **Conclusions:** Morbidity, mortality, ICU stay, and healthcare costs are significant in *C. auris* infection.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.664

	Area 1 ICU/HDU/Surgical Bay	Area 2 General /Emergency ward	Area 3 Private ward
Cluster 2			
MR/19/001858	▲ ■	-	■
MR/18/010448	-	▲ ■	-
MR/18/017471	▲ ■	■	-
MR/13/004285	-	▲	-
MR/19/005106	▲	■	-
Cluster 1			
MR/18/011942	▲ ■	■	-
MR/18/017317	▲ ■	-	-
MR/17/010086	▲ ■	■	-
MR/17/010584	-	▲ ■	-
MR/16/010836	▲ ■	■	-
MR/17/012502	▲ ■	-	-

▲ Patient's location at the time of positivity ■ Patient location before positivity

Fig. 1.

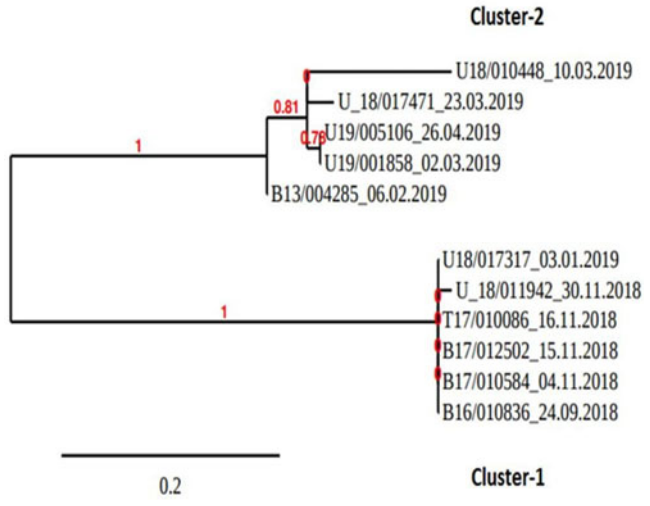

Fig. 2.

Presentation Type:
Poster Presentation

***Candida auris* Outbreak Control in Critical Care Units in a Tertiary-Care Hospital in Nairobi, Kenya**

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Background: *Candida auris* is an emerging pathogen associated with nosocomial outbreaks. During January to May 2019, 11 invasive cases of *C. auris* were identified in the intensive care unit (ICU) and high-dependency unit (HDU) at a hospital in Nairobi, Kenya. We report on the interventions implemented to control the outbreak. **Methods:** Intensified infection prevention and control (IPC) interventions were implemented. All patients infected or colonized with *C. auris* were placed in single-patient rooms with strict contact precautions. Cleaning of the patient care environment was enhanced by instituting a 3-step procedure of cleaning with soap and water, disinfecting with 0.5% chlorine, and rinsing with water. Glo-Germ gel was used to evaluate the cleaning processes, and percentage of missed surfaces was calculated. Hand hygiene training and compliance observations were conducted to enforce adherence to hand hygiene. The IPC team provided training and observational feedback of IPC to staff, patients, and their families. The IPC interventions were guided by screening activities. To monitor ongoing transmission, a biweekly point-prevalence survey (PPS) was performed to screen all previously negative ICU and HDU patients for *C. auris*. Furthermore, admission and contact screening were added to