Conclusion. This pooled analysis demonstrated that eravacycline 1 mg/kg IV q12h was generally well tolerated for the treatment of cIAI when compared with ertapenem and meropenem. Results of the analysis are consistent with those of individual clinical studies and no new safety signals were identified.

Disclosures. E. Efimova, Tetrphase Pharmaceuticals: Employee, Salary. M. Olesky, Tetrphase Pharmaceuticals: Employee and Shareholder, Salary. S. Izmailyan, Tetrphase Pharmaceuticals: Employee, Salary. L. Tsai, Tetrphase Pharmaceuticals: Employee and Shareholder, Salary.

1977. Comparative Effectiveness of Linezolid vs. Trimethoprim-Sulfamethoxazole for Acute Bacterial Skin and Skin Structure Infections (ABSSIs) at a Veterans Affairs Hospital

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Background. Linezolid (LZD) and trimethoprim-sulfamethoxazole (TMP-SMX) are both used in the treatment of acute bacterial skin and skin structure infection (ABSSI) with differing adverse event profiles to guide usage, but their comparative efficacies in severe ABSSI remain unclear.

Methods. This retrospective cohort study evaluated patients admitted to the VA St. Louis Health Care System for treatment of an ABSSI between April 18, 2000 and October 16, 2017 and discharged with a prescription for ≥5 days of LZD or TMP-SMX. The primary outcome was clinical failure, defined as a composite of an Emergency Department visit, clinic visit, inpatient admission, extension of antibiotics, change of antibiotic regimen for any reason, or the presence of an adverse reaction occurring in the 14 days after completion of the outpatient regimen. Adverse reactions evaluated were acute kidney injury, hyperkalemia, neutropenia, thrombocytopenia, and anemia. The secondary outcome evaluated risk factors for clinical failure with multivariate logistic regression analysis. Potential factors to be included in the analysis were drug choice, duration of intravenous antibiotic use while inpatient (<24 hours, ≥24 hours to ≤48 hours, >48 hours), identification of methicillin-resistant *Staphylococcus aureus* (MRSA) in culture, MRSA nasal colonization, and incision and drainage.

Results. A total of 139 patients were included in the analysis; 51 treated with LZD and 88 treated with TMP-SMX. Length of hospital stay was greater in the LZD group (6.05 days vs. 3.69 days [$P = 0.023$]), as was antibiotic use during hospitalization (98% [49/50] vs. 86% [77/90]; $P = 0.019$). The mean day supply of antibiotic dispensed at discharge was 10.18 in the LZD group and 9.64 in the TMP-SMX group ($P = 0.48$). Twenty-two percent (11/51) of patients treated with LZD and 18% (16/88) of those treated with TMP-SMX ($P = 0.878$) experienced clinical failure. Only receipt of antibiotics for 24–48 hours during hospitalization met criteria for inclusion in the multivariate analysis, but was not significantly associated with clinical failure (0.367 [95% CI 0.083–1.63]; $P = 0.187$).

Conclusion. There was no difference in the rate of clinical failure between patients treated with LZD or TMP-SMX for severe ABSSI.

Disclosures. All authors: No reported disclosures.

1978. Efficacy of Eravacycline in Secondary Bacteremia: A Post Hoc Analysis of Two Phase 3 studies of Complicated Intra-Abdominal Infection

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Background. Eravacycline is a novel, fully synthetic fluorocycline antibiotic that was evaluated for the treatment of complicated intra-abdominal infections (cIAI) in two Phase 3 (IGNITE1 and IGNITE4) clinical trials. The objective of this analysis was to evaluate microbiological response at the test of cure (TOC) visit in patients with baseline bacteremia who received eravacycline vs. comparators (ertapenem and meropenem).

Methods. Pooled data from IGNITE1 and IGNITE4 studies were analyzed. All patients enrolled were randomized (1:1) to receive eravacycline (1 mg/kg IV q12h) or ertapenem 1 g IV q24h, (IGNITE1 study) or meropenem 1g IV q8h, (IGNITE4 study) for 4–14 days. Blood (aerobic and anaerobic bottles) and intra-abdominal samples were collected from all patients. Clinical outcome at the TOC visit (28 days after randomization) in the microbiological-intention to treat population (micro-ITT) was the primary efficacy endpoint.

Results. Four hundred fifteen patients were treated with eravacycline and 431 with comparators of which 39 (9.4%) and 40 (9.3%), respectively, had concurrent bacteremia. Demographic and baseline characteristics were similar among the groups. In the micro-ITT population, the pooled clinical response at the TOC visit for eravacycline vs. comparators was 88.7% and 89.3% (–0.7; 95% CI, –4.9, 3.6), respectively. The baseline pathogens associated with concurrent bacteremia and the microbiological eradication for selected pathogens are presented in Table 1.

Table 1. Microbiological Eradication at the Test of Cure Visit by Baseline Pathogen from Blood Specimen

	Eravacycline, (N = 415), n (%)	Comparators ^a , (N = 431), n (%)
Gram-negative	14/15 (93.3)	14/15 (93.3)
<i>E. coli</i>	5/6 (83.3)	6/7 (85.7)
Gram-positive	15/15 (100)	11/11 (100)
<i>Streptococcus</i> spp.	8/8 (100)	4/4 (100)
<i>Enterococcus</i> spp.	2/2 (100)	5/5 (100)
Anaerobes	9/9 (100)	13/14 (92.9)
<i>Bacteroides</i> spp.	6/6 (100)	8/8 (100)

^aMeropenem and ertapenem.

Conclusion. Eravacycline demonstrated a similar microbiological eradication rate as comparator agents in patients with cIAI associated with secondary bacteremia.

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1979. Time to Viral Suppression Does Not Impact SVR in Patients Treated With Glecaprevir/Pibrentasvir for 8 Weeks

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Background. The pangenotypic direct-acting antivirals (DAAs) glecaprevir (developed by AbbVie and Enanta) coformulated with pibrentasvir (G/P) are approved as an 8-week regimen to treat chronic HCV infection for all six major genotypes (GT). An integrated analysis of patients treated with G/P for 8 weeks was performed to investigate factors impacting time to viral suppression, and whether lack of viral suppression by treatment week 4 was predictive of relapse.

Methods. Data were pooled from five phase 2 or 3 clinical studies, and included patients with HCV GT 1–6 infection without cirrhosis who were either treatment naïve or experienced with IFN or pegIFN with or without ribavirin (RBV) or sofosbuvir and RBV with or without pegIFN. G/P (300 mg/120 mg) was orally dosed once-daily for 8 weeks. Patients lost to follow-up or with missing SVR12 data ($N = 13$) were excluded from the analysis since the impact of viral suppression (HCV RNA below lower limit of quantification [LLOQ]) on response cannot be assessed in these patients. Two patients with on-treatment virologic failure were excluded since we sought to determine whether detectable HCV RNA at treatment week 4 was predictive of relapse.

Results. The analysis included 950 patients; 63 (7%) were black, 171 (18%) had BMI ≥30, and 24% had baseline HCV RNA ≥6 million. The majority of patients were white, male, and HCV treatment-naïve. Among 942 patients with data, 906 (96%) had HCV RNA <LLOQ at treatment week 4, and of those, 899/906 (99%; 95% CI 98.4–99.6) achieved SVR12; additional results by subgroups are in Table 1. There was no common baseline factor more frequently observed among the seven patients who relapsed other than male sex (5/7; 71%). Of the 36 patients with HCV RNA >LLOQ at treatment week 4 (median baseline HCV RNA 6.7 log₁₀ IU/mL; range 5.2–7.6 log₁₀ IU/mL), 100% (95% CI 90.4–100.0) achieved SVR12.

Conclusion. In patients treated with G/P for 8 weeks, failure to suppress HCV RNA by treatment week 4 was not predictive of treatment outcome, suggesting that treatment extension in patients eligible for 8-week regimens based on this milestone is not warranted. Data will also be presented for patients with compensated cirrhosis treated with 12 or 16 weeks of G/P.

Table 1.

	Patients with HCV RNA < LLOQ at Treatment Week 4, n/N (%)	Patients with SVR12, n/N (%)
Total	906/942 (96)	943/950 (99)
Subgroup		
HCV RNA <6,000,000 IU/mL ^a	695/716 (97)	720/724 (99)
HCV RNA ≥6,000,000 IU/mL ^a	211/226 (93)	223/226 (99)
BMI <30 kg/m ²	737/772 (96)	774/779 (99)
BMI ≥30 kg/m ²	169/170 (99)	169/171 (99)
Black race	63/63 (100)	63/63 (100)
Non-black race	843/879 (96)	880/887 (99)
HCV genotype 3	184/198 (93)	198/203 (98)
Treatment-compliant ^b	805/835 (96)	832/839 (99)
Treatment non-compliant ^b	101/107 (94)	111/111 (100)

^a8 patients missing data at treatment week 4

^bFor phase 2 studies, HCV RNA levels quantified by COBAS AmpliPrep/TaqMan[®] RT-PCR assay v. 2.0; LLOQ = 15 IU/mL. For phase 3 studies, HCV RNA levels were manually processed using the High Pure System and quantified by COBAS TaqMan[®] RT-PCR assay v. 2.0; LLOQ = 25 IU/mL.

^cTreatment compliance measured by pill count; values <80% and/or >120% were considered non-compliant.

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1980. Efficacy of an Oral Vancomycin Loading Dose (LD) in the Treatment of Confirmed *Clostridium difficile* Infection (CDI)

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Background. Over the past decade the incidence and severity of CDI has increased significantly. The 2018 IDSA Guidelines now recommends oral vancomycin 125 mg every 6 hours as the first-line therapy for initial occurrence of CDI. However, the optimal dosage of vancomycin is not well established. Pharmacokinetic data demonstrate that patients who receive 125 mg every 6 hours may have low fecal levels of vancomycin during the first 24 hours of therapy. Given that the fecal levels are relatively proportional to the dosage administered, a vancomycin LD may improve clinical outcomes. This study compared two vancomycin oral dosing regimens in patients with CDI.

Methods. A retrospective study evaluating pre and post-implementation of a 48-hour LD of vancomycin 500 mg every 6 hours was conducted. The control group included patients from January 2013 to January 2016. The intervention group included patients from February 2016 to December 2017, after the implementation of an LD as part of the order in the electronic medical record. Included subjects had confirmed CDI defined as diarrhea plus a positive *C. difficile* antigen and a positive rapid toxin by ELISA or positive cytotoxin. Subjects were excluded if they were <18 years of age, history of CDI in the past 90 days, received metronidazole within 24 hours of vancomycin initiation, or were treated for CDI in the past 28 days. The primary outcome was time to resolution of diarrhea defined as the interval, in days, from the start of treatment until the last unformed bowel movement. Secondary outcomes included clinical cure, defined as resolution of diarrhea and symptoms with no need for further treatment and recurrence of CDI.

Results. Three hundred ten patients were enrolled in the study with 155 patients in each arm. Time to resolution of symptoms was faster in the LD group compared with the control group (4 vs. 4.5 days; $P = 0.05$). There was no significant difference between the LD and control groups with respect to clinical cure (90% vs. 85%; $P = 0.17$); but patients <65 years had a higher clinical cure rate using the LD (95% vs. 84%; $P = 0.03$).

Conclusion. An oral vancomycin LD for CDI therapy was associated with a decrease in time to resolution of symptoms. Patients aged <65 years had improved clinical cure with the LD. Additional prospective studies are needed to clarify the optimal oral vancomycin dosing strategy.

Disclosures. All authors: No reported disclosures.

1981. Real-World Data on Safety and Effectiveness of Glecaprevir/Pibrentasvir for the Treatment of Patients With Chronic Hepatitis C Virus Infection on Opioid Substitution Therapy: Latest Results from the German Hepatitis C-Registry

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Background. The coformulated direct-acting antivirals glecaprevir/pibrentasvir (G/P) are approved to treat chronic hepatitis C virus (HCV) genotype 1–6 infection. In clinical trials, G/P demonstrated high efficacy, but real-world data in patients on opioid substitution therapy (OST), a population for which antiviral treatment is critical for HCV elimination, are limited. Here we report the first real-world data on the effectiveness and safety of G/P for OST patients within the German Hepatitis C-Registry (DHC-R).

Methods. The DHC-R is an ongoing, noninterventional, multicenter, prospective, monitored registry study. Data were collected between July 28, 2017 and February 9, 2018 from 104 sites in Germany. The analysis included adult HCV-infected patients who were treated with G/P according to the European Medicines Agency label. The primary endpoint was sustained virologic response at post-treatment week 12 (SVR12). Safety and tolerability were assessed in patients that completed treatment.

Results. As of February 9, 2018, 638 patients had initiated on-label treatment with G/P and are included in the baseline analysis. Patients on OST comprised 26% (168/638) of the baseline population, of which most patients were treatment-naïve, without cirrhosis and had HCV genotype 1a or 3. Among patients with available SVR12 data, 96% (27/28) of OST patients and 97% (66/68) of non-OST patients achieved SVR12. There were no virologic failures: of three early discontinuations, one OST patient was lost to follow-up and two non-OST patients discontinued treatment due to adverse events (AE). In the modified intention-to-treat population which excluded non-virologic failures, SVR12 was 100% for both OST and non-OST patients. The safety population included 321 patients in total. Among OST patients, 2% (2/84) experienced serious AEs (SAE) without any treatment discontinuations due to AE/SAE.

Conclusion. In this real-world analysis, G/P treatment yielded favorable effectiveness and safety results in patients on OST. Updated data and SVR12 results will be presented.

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1982. Multiplex PCR-Based Analysis of Enteric Pathogens in Faecal Samples from Patients with *Clostridium difficile* Infection in the Randomized, Controlled EXTEND Study Comparing the Efficacy of Extended-Pulsed Fidaxomicin With Vancomycin Therapy

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Background. Extended-pulsed fidaxomicin (EPFX) was equivalent to standard vancomycin (SV) for resolving *Clostridium difficile* infection (CDI) in the EXTEND study. Sustained clinical cure (SCC) at 30 days after end of treatment (EOT) was achieved in 124/177 (70%) patients receiving EPFX vs. 106/179 (59%) patients receiving SV (difference 11%; $P = 0.030$). The BioFire platform, a multiplex PCR-based method, was used to detect possible enteric co-pathogens in patients from EXTEND.

Methods. Patients aged ≥60 years with positive local test for CDI were randomized (1:1) to receive either EPFX (200 mg tablets, twice daily on Days 1–5 and once daily on alternate days on Days 7–25) or SV (125 mg capsules, four times daily on Days 1–10). Stool samples were collected from all patients at screening and analysed using the BioFire FilmArray Gastrointestinal (GI) panel (Biomérieux). The primary endpoint was the rate of SCC at 30 days after EOT, defined as clinical response (determined by the investigator) and no CDI recurrence. Patients were grouped according to BioFire results, and clinical outcomes were then compared using the chi-square test and logistic regression analyses.

Results. At screening, all patients tested positive for *C. difficile* toxin A/B by local laboratory test, and 286/332 patients tested positive for *C. difficile* by BioFire (Figure 1). SCC rates at 30 days after EOT, by baseline presence/absence of enteric