Table 1 Patient and Clinical Characteristics of patients who received repeat blood cultures and those who did not			
	Repeat Blood cultures (n=283)	**Blood cultures not repeated (n=72)**	**p-value**
Age	71 (60, 79)	74 (63,82)	0.11
Sex			
Male	163 (57.6)	43 (59.7)	0.79
Female	120 (42.4)	29 (40.3)	
Dialysis	15 (5.30)	2 (2.8)	0.54
Diabetes	114 (40.3)	22 (30.6)	0.14
Cirrhosis	25 (8.80)	4 (5.6)	0.47
Immunocompromised	37 (13.1)	12 (16.7)	0.45
Severity of presentation			
Pitt	2 (0,3)	2 (0,3)	0.99
qSOFA	1 (0,2)	1 (0,2)	0.44
ICU stay	104 (36.7)	25 (34.7)	0.79
ID Consult	230 (81.3)	41 (56.9)	<0.001
Active Abx Coverage at time of blood culture	231 (81.6)	61 (84.7)	0.61
Organisms and infection source			
Polymicrobial	46 (16.3)	5 (6.9)	0.058
ESBL or CRE	39 (13.8)	13 (18.1)	0.36
Organism			0.089
Enterobacterales	197 (69.6)	50 (69.4)	
Pseudomonas	15 (5.30)	5 (6.9)	
Other	26 (9.20)	12 (16.7)	
Polymicrobial	45 (15.9)	5 (6.9)	
Source of infection			
GU	147 (51.9)	43 (59.7)	0.29
GI	23 (8.10)	5 (6.9)	
Hepatobiliary	24 (8.50)	7 (9.7)	
Pulmonary	15 (5.30)	4 (5.6)	
SSTI or Bone and Joints	24 (8.50)	4 (5.6)	
Line or Device	13 (4.60)	0 (0.0)	
Other	5 (1.80)	1 (1.4)	
Unknown	32 (11.3)	8 (11.1)	
Surgical Infection	12 (4.2)	6 (8.3)	0.22
Foley catheter	20 (7.1)	4 (5.6)	0.8
Suprapubic catheter	7 (2.50)	2 (2.8)	1
Peripheral line	3 (1.10)	0 (0.0)	0.38
Central line	10 (3.50)	1 (1.4)	0.7
Cardiovasc Devices	2 (0.70)	0 (0.0)	0.47
Stent as source	4 (1.40)	1 (1.4)	0.99
Bone Hardware	3 (1.10)	0 (0.0)	0.38
Any Hardware	9 (3.20)	1 (1.4)	0.41
Source Control Achieved	83 (29.3)	18 (25.0)	0.56

Table 2 Patient and Clinical Characteristics of patients who had positive blood cultures and those who did not			
	Repeat Blood cultures negative (n=244)	**Blood cultures positive (n=39)**	**p-value**
Age	71 (61, 79)	72 (58, 78)	0.97
Sex			0.61
Male	139 (57.0)	24(61.5)	
Female	105 (43.0)	15(38.5)	
Dialysis	11 (4.50)	4(10.3)	0.29
Diabetes	100 (41.0)	14(35.9)	0.6
Cirrhosis	22 (9.00)	3(7.70)	1
Immunocompromised	33 (13.5)	4(10.3)	0.8
Severity of presentation			
Pitt	2 (0,3)	2 (1,4)	0.014
qSOFA	1 (0, 1)	1 (0,2)	0.034
ICU stay	80 (32.8)	24(61.5)	<0.001
ID Consulted	194 (79.5)	36(92.3)	0.08
Active Abx Coverage at time of blood cultures	201 (82.4)	30(76.9)	0.5
Organisms and infection source			
Polymicrobial	39 (16.0)	7(17.9)	0.82
ESBL or CRE	212 (86.9)	32(82.1)	0.45
	32 (13.1)	7(17.9)	
Organism			
Enterobacterales	171 (70.1)	26(66.7)	0.89
Pseudomonas	12 (4.90)	3(7.70)	
Other	23 (9.40)	3(7.70)	
Polymicrobial	38 (15.6)	7(17.9)	
Source of infection			_
GU	123 (50.4)	24(61.5)	
GI	18 (7.40)	5(12.8)	
Hepatobiliary	21 (8.60)	3(7.70)	
Pulmonary	15 (6.10)	0(0.00)	
SSTI or Bone and Joints	24 (9.80)	0(0.00)	
Line or Device	9 (3.70)	4(10.3)	
Other	4 (1.60)	1(2.60)	
Unknown	30 (12.3)	2(5.10)	
Surgical Infection?	9 (3.70)	3(7.70)	0.25
Foley catheter	17 (7.00)	3(7.70)	1
Suprapubic catheter	6 (2.50)	1(2.60)	1
Peripheral line	1 (0.40)	2(5.10)	0.051
Central line	9 (3.70)	1(2.60)	1
Cardiovasc Devices	1 (0.40)	1(2.60)	0.26
Stent as source (Biliary, Uro, etc.)	3 (1.20)	1(2.60)	0.45
Bone Hardware	3 (1.20)	0	1
Any Hardware	7 (2.90)	2(5.10)	0.36
Source Control Achieved	69 (28.3)	14(35.9)	0.35

immunocompromised status, co-morbidities, or age between the two groups. The most common organisms detected were Enterobacterales, followed by Pseudomonas. The most common source of infection was overwhelmingly genitourinary, followed by gastrointestinal and hepatobiliary.

‡The abstract titles in this supplement have been corrected since original publication. A notice detailing the changes has been published at https://doi.org/10.1017/ash.2026.10802.

Table 3 Primary and Secondary Outcome Comparison Between Patients who received repeat blood cultures and those who did not					
		Repeat Blood cultures (n=283)	**Blood cultures not repeated (n=72)**	**Odds ratio (95% CI)**	**p-value**
30 Day Mortality	No	254 (89.8)	58 (80.6)	0.74 (0.36, 1.55)	0.43
	Yes	29 (10.2)	14 (19.4)		
90 Day Infection Recurrence	No	274 (96.8)	70 (97.2)	0.86 (0.16, 4.47)	0.85
	Yes	9 (3.2)	2 (2.8)		
Planned Duration of Abx Tx	7days or less	48 (17.0)	27 (37.5)	2.28 (1.23, 4.25)	0.009
	More than 7 days	234 (83.0)	45 (62.5)		
Length of Stay					
Total Length of Stay		7 (5,12)	5 (3,9)	0.09 (0.02, 0.34)	<0.001
Length of Stay Post-Culture		7 (5,11)	4 (3,7)	0.11 (0.02, 0.51)	0.005

Table 4 Primary and Secondary Outcome Comparison Between Patients who had positive blood cultures and those who did not					
		Repeat Blood cultures negative (n=257)	**Blood cultures positive (n=43)**	**Odds ratio (95% CI)**	**p-value**
30 Day Mortality	No	223 (91.4)	31(79.5)	0.51 (0.19, 1.42)	0.2
	Yes	21 (8.60)	8(20.5)		
90 Day Infection Recurrence	No	235 (96.3)	39(100.)	_	
	Yes	9 (3.70)	0(0.00)		
Planned Duration of Abx Tx	7days or less	43 (17.6)	5 (13.2)	0.45 (0.15, 1.39)	0.17
	More than 7 days	201 (82.4)	33 (86.8)		
Length of Stay					
Total Length of Stay		7 (5, 11)	10 (5, 19)	0.81 (0.61, 1.06)	0.12
Length of Stay Post-Culture		6 (5, 10)	10 (6, 17)	0.10 (0.01, 1.26)	0.07

There were no significant differences between those who did and did not undergo FUBC for odds of 30-day mortality (OR 0.74 (0.36-1.55)) or 90-day reinfection (OR 0.86 (0.16-4.47)). However, FUBC were associated with significantly longer median hospital stay (7 days vs 5 days, p < 0.001) and higher odds of receiving <7 days of antibiotics (OR 2.28, (1.23-4.25), p = 0.009). Persistent bacteremia despite appropriate therapy occurred more frequently among patients with ICU admission, though clinical impact could not be fully assessed. Additionally, patients with an Infectious Diseases consult were more likely to have FUBC. No other subgroup was significantly more likely to have blood cultures repeated. **Conclusions:** The use of FUBC in GNB did not demonstrate improvement in mortality or reinfection rates. Instead, FUBC correlated with prolonged hospitalization and extended antibiotic therapy. It remains unclear whether FUBC offers significant clinical benefit in higher-risk groups. Further research is needed to clarify the role of FUBC in critically ill patients.

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Presentation Type:
Poster Presentation
Subject Category: Diagnostic Stewardship

Synovial Fluid PCR Testing Paired with Culture Can Improve Pathogen Identification‡

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Background: Pyogenic arthritis is a commonly encountered condition by Infectious Diseases clinicians and can occur in native joints as well as

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prosthetic joints. Synovial fluid culture is key in identifying the pathogen but there is a high incidence of culture-negative infections – up to 40% in native pyogenic arthritis and up to 15% in prosthetic joint infections. Multiplex polymerase chain reaction (PCR) testing offers the potential for rapid organism identification but real-world data on utilization of the test is lacking. **Methods:** A health system in the Chicagoland area recently began use of the BIOFIRE® Joint Infection Panel, which tests for 39 common bacterial and fungal causes of joint infection, as well as several markers of antimicrobial resistance. If the PCR is ordered, a synovial fluid culture must also be ordered. Of note, coagulase-negative staphylococci and Cutibacterium acnes are not targets on the PCR panel. A retrospective review was conducted of synovial fluid PCR testing among 5 hospitals from 1/1/25 – 12/6/25. **Result:** A total of 168 synovial fluid PCR tests were sent and 48 (28.4%) were positive. Age, gender, and race/ethnicity were similar between the PCR-positive and PCR-negative groups. In the PCR-positive and PCR-negative groups, 54.2% and 57.5% of patients had a prosthetic joint, respectively. All patients also had a synovial fluid culture obtained. Among patients with a positive PCR test, PCR and culture results were concordant for 31 (64.6%) patients. Of the 17 patients with a positive PCR but a discordant culture result, 14 had a negative synovial fluid culture and 3 had a culture identifying the organism found on PCR but also a second bacteria (Staphylococcus epidermidis, C. acnes, Finegoldia magna). Additionally, 90.8% of negative PCR tests had a corresponding negative culture result. Among the 12 patients with a negative PCR and a positive culture, six (50%) had growth of organisms included on the PCR panel (Staphylococcus aureus [n=2], Pseudomonas aeruginosa [n=2], Escherichia coli [n=1], Streptococcus infantarius [n=1]). The remaining isolates (Pasteurella multocida, Corynebacterium striatum, S. epidermidis [n=2], Dermabacter hominis, and Haemophilus parainfluenzae) were off-panel organisms. **Conclusion:** Synovial fluid PCR paired with culture can decrease the incidence of pyogenic arthritis without an identifiable pathogen among patients with native and prosthetic joint infections. Further research should examine the impact of the PCR test on antibiotic use, including time to targeted therapy, which may inform diagnostic stewardship recommendations regarding the test.

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Poster Presentation
Subject Category: Diagnostic Stewardship

Evaluating the Effect of Educational Interventions On Inappropriate Urinalysis with Reflex to Culture Orders in Catheterized Patients‡

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Background: Inappropriate urine culture ordering among catheterized patients can result in overdiagnosis of catheter-associated urinary tract infections (CAUTI) and unnecessary antibiotic exposure. We sought to reduce inappropriate urine culture ordering at our 167 bed acute care hospital with targeted diagnostic stewardship educational initiatives to hospitalist, emergency room, and intensive care unit providers (ICU). Objective: Estimate the impact of educational workshops on appropriate urinary ordering practices among inpatient providers at a single small acute care hospital. **Methods:** Retrospective observational cohort study of all catheterized patients receiving a urinalysis with reflex to culture from March 2023-April 2025. Workshops were held during different months tailored to provider groups, and attendance was recorded. Categorization of order indications and appropriateness were assessed retrospectively by a study team member applying established algorithms (i.e., IDSA guidelines with minor modifications). Patient clinical and encounter data were extracted from the electronic health record. Indications and appropriateness of orders were compared between provider groups and by provider attendance at a workshop by univariate and multivariate analysis. **Results:** Of 139 urinalyses with reflex to culture orders, 63 (45%) were ordered by Hospitalists, 40 (29%) by critical care providers, and 36 (26%) by other provider groups; 81 (59.6%) were inappropriate, without differences in appropriateness by provider group (p=0.10). Frequency of ordering decreased over time (7.2/month prior to last workshop vs. 4.2/month after, Figure); however, the proportion categorized as inappropriate appeared stable over time (Figure). Appropriate orders were mostly for UTI symptoms without fever (14, 25.5%), with fever (10,18.2%), or sepsis (16, 29.1%). Provider workshop attendance was as frequent among appropriate orders as inappropriate (25/55, 46% vs. 26/81, 32%, p=0.12). There were no significant differences in catheter duration, comorbidity score, and various primary discharge diagnosis by order appropriateness. **Conclusion:** Over two years, a majority of urinalysis with reflex to culture orders among catheterized patients were inappropriate. While diagnostic stewardship workshop attendance did not appear to impact likelihood of an order to be appropriate, we did observe an overall decrease in orders suggesting educational efforts may have influenced ordering behavior.

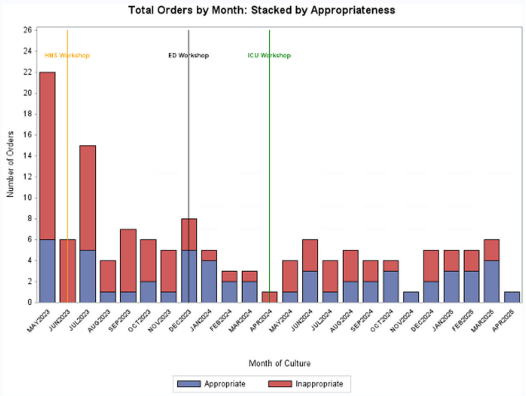


Figure. Count of urinalysis with reflex to culture orders among catheterized patients per month, by appropriateness of categorization. Vertical lines represent the timing of provider-group diagnostic stewardship workshops.

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System Impact and Yield of Routine Pulmonary TB Rule-Out in Extrapulmonary TB Evaluation: Isolation, Costs, and PPE Utilization‡

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Background At University of Washington Medical Center (UWMC), patients undergoing evaluation for extrapulmonary tuberculosis (EPTB) are routinely placed in airborne precautions and undergo pulmonary tuberculosis (PTB) rule-out, regardless of epidemiologic risk factors or pulmonary symptoms. This approach was implemented to support early identification of occult PTB in asymptomatic individuals. While prior small studies suggest PTB may occur infrequently among patients with EPTB without pulmonary symptoms, CDC guidance recommends PTB evaluation based on clinical suspicion and epidemiologic risk. The clinical yield and operational, financial, and environmental impacts of UWMC's universal approach are unclear; this study characterizes its utility and burden. Methods We conducted a retrospective descriptive analysis of adult patients evaluated for EPTB at a low TB-incidence tertiary-care academic medical center (April 2024–December 2025). Data were exempt from IRB review. Outcomes included patient characteristics (including hematology-

‡The abstract titles in this supplement have been corrected since original publication. A notice detailing the changes has been published at https://doi.org/10.1017/ash.2026.10802.

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