to determine the effect of this respiratory PCR test on duration of anti-MRSA therapy in non-intensive care unit (ICU) patients hospitalized with pneumonia.

Methods. Implementation of the PCR test in non-ICU units occurred December 1, 2017. During the post-intervention (INT) period (December 1, 2017–March 31, 2018), PCR results were evaluated daily by antimicrobial stewardship and decentralized staff pharmacists for therapy de-escalation opportunities, with recommendations communicated to prescribers. The pre-INT group (December 1, 2016–March 31, 2017) consisted of non-ICU patients hospitalized with pneumonia who received anti-MRSA therapy for at least 48 hours, or who qualified for anti-MRSA therapy per institutional guidelines.

Results. A total of 169 patients were evaluated; 109 in the post-INT group and 60 in the pre-INT group. Anti-MRSA therapy was administered to 74 patients (68%) in the post-INT group, compared with 56 patients (93%) in the pre-INT group. The median duration of anti-MRSA therapy post-INT was 25.5 hours, which was significantly shorter than the pre-INT duration of 55.5 hours ($P < 0.0001$). The post-INT group also had significantly less vancomycin-induced nephrotoxicity ($P = 0.0383$) and a shorter time to targeted therapy ($P < 0.0001$). No difference in 30-day all-cause mortality was observed ($P < 0.1338$).

Conclusion. Utilization of a PCR test to detect MRSA in respiratory specimens decreased duration of anti-MRSA therapy in non-ICU patients hospitalized with pneumonia.

Disclosures. All authors: No reported disclosures.

1459. The Scope of Mycoplasma Pneumoniae Pneumonia Diagnosed by Multiplex Polymerase Chain Reaction Respiratory Viral Panel in Pediatric Patients in Hawaii
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Background. Mycoplasma pneumoniae pneumonia (MPP) is classically associated with infections in mild older children with mild virulence in younger children. The multiplex polymerase chain reaction (PCR) respiratory viral panel (RVP) allows for diagnosis of multiple viruses and bacteria.

Methods. A retrospective study was performed in patients 0–18 years old with positive MPP RVP from January 1, 2013 to June 30, 2017. Clinical cases of patients hospitalized with positive MPP testing by RVP PCR were reviewed for clinical, radiologic and laboratory data.

Results. A total of 3,621 RVPs were tested with 49 positive for MPP. In regard to age of patients, 151/279 (incidence 5.4%) were positive for MPP testing compared with 22/49 (incidence 1%) between 5–18 years old. 75% of RVPs obtained were in patients under 5 years of age. Cough and fever were present for a mean of 8.3 and 7.6 days, respectively prior to RVP. Of the MPP positive patients, 21/49 (43%) were treated with scheduled although only 16 had a history of wheezing. Of the MPP positive patients, 38/49 patients had radiological findings of a pulmonary infiltrate (not peripherally) with 30/38 patients (79%) had bilateral infiltrates. Admission antimicrobial therapy was the following: 8 on no antibiotic, 21 on monomicrobioc, 11 on macrolide and macrolides, and 9 on macrolide therapy alone. Pediatric intensive care unit (PICU) admission occurred in 8 patients due to PICU admissions of a pulmonary infiltrate (not peripherally) with 30/38 patients (79%) had bilateral infiltrates. Admission antimicrobial therapy was the following: 8 on no antibiotic, 21 on monomicrobioc, 11 on macrolide and macrolides, and 9 on macrolide therapy alone. Pediatric intensive care unit (PICU) admission occurred in 8 patients due to PICU admissions of a pulmonary infiltrate (not peripherally) with 30/38 patients (79%) had bilateral infiltrates. Admission antimicrobial therapy was the following: 8 on no antibiotic, 21 on monomicrobioc, 11 on macrolide and macrolides, and 9 on macrolide therapy alone. Pediatric intensive care unit (PICU) admission occurred in 8 patients due to PICU admissions of a pulmonary infiltrate (not peripherally) with 30/38 patients (79%) had bilateral infiltrates. Admission antimicrobial therapy was the following: 8 on no antibiotic, 21 on monomicrobioc, 11 on macrolide and macrolides, and 9 on macrolide therapy alone. Pediatric intensive care unit (PICU) admission occurred in 8 patients due to PICU admissions of a pulmonary infiltrate (not peripherally) with 30/38 patients (79%) had bilateral infiltrates. Admission antimicrobial therapy was the following: 8 on no antibiotic, 21 on monomicrobioc, 11 on macrolide and macrolides, and 9 on macrolide therapy alone. Pediatric intensive care unit (PICU) admission occurred in 8 patients due to PICU admissions of a pulmonary infiltrate (not peripherally) with 30/38 patients (79%) had bilateral infiltrates.

Conclusion. Over half of Pediatric MPP was diagnosed by rapid molecular diagnostic in patients under 5 years of age. Bilateral pulmonary infiltrates and new onset wheezing responsive to β agonists were commonly noted in patients who had MPP. A small subset of those younger patients required higher level of care after initial therapy with nonmacrolide therapy. While MPP has a lower incidence among younger children, infection is not rare and can have a significant clinical impact. MPP should be considered in all patients, especially younger patients who are nonresponsive to treatment of community acquired pneumonia.

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