admission, mechanical ventilation (MV), parenteral/tube feeding, inpatient rehab, or intracranial pressure monitoring. Single variable and multivariate analyses were performed to determine factors predictive of disease severity.

**Results.** Of the 140 patients, 76 (54%) males with a median age of 8 years (10 months-16 years), were identified with LACV-ND. Symptoms at presentation, laboratory abnormalities, EEG, radiographic, and outcome are shown in Table 1. Fifty-seven (41%) patients met criteria for severe disease, notably for PICU admission (n = 41), status epilepticus (n = 35), MV (n = 13), and inpatient rehab (11). No in-patient deaths were observed. Exploratory analysis revealed that patients with severe disease were significantly younger at presentation, had higher rates of altered mental status (AMS) and seizures. Elevated serum white blood cell counts (WBC) and polymorphonuclear cell (PMN) predominance in serum and cerebrospinal fluid (CSF) were observed more frequently in severe disease. Multivariate analysis revealed presentation with seizures (OR 4.7 [95% CI 1.7–12.6; P = 0.001), elevated serum WBC (OR 1.7 [95% CI 1.2–2.5; P = 0.004), and a higher CSF PMN% (OR 1.03 [95% CI 1.01–1.06, P = 0.003) to be independent predictors of severe disease.

**Conclusion.** At presentation, patients with severe disease tended to be younger, have greater rates of psychiatric symptoms, and leukocytosis with PMN predominance in blood and CSF. These clinical and laboratory findings may serve as useful biomarkers to predict disease severity.

| Table 1: Clinical, Laboratory, Radiographic Findings, and Outcomes with Pediatric LaCrosse Virus Infection |
|---------------------------------------------------------|
| **Neuroinvasive Disease** | **Cohort** | **Severe** | **Non-severe** | **P-value** |
| Age, in days, median (IQR) | 8 [6-11] | 7 [6-11] | 8 [6-11] | 0.44 |
| Age > 5 years, n (%) | 34 (24%) | 14 (19%) | 17 (24%) | 0.046 |
| Location, median (IQR) | 106 [100-110] | 106 [97-107] | 106 [100-110] | 0.22 |
| Duration of symptoms, in days, median (IQR) | 4 (3-6) | 3 (2-4) | 4 (3-6) | 0.0094 |
| Fever, n (%) | 128 (90%) | 40 (60%) | 88 (95%) | 0.0001 |
| AMS, n (%) | 84 (60%) | 47 (62%) | 37 (40%) | <0.0001 |
| Seizures, n (%) | 32 (22%) | 39 (56%) | 17 (21%) | <0.0001 |
| Hypothermia, n (%) | 41 (28%) | 32 (46%) | 9 (11%) | <0.0001 |
| Laboratory Values | | | | |
| Serum RRV (nC5) median, (IQR) | 14.0 [12.5–17.8] | 17.3 [12.1-21.3] | 13.3 [10.5–19.5] | 0.0005 |
| Serum ANC (95% CI), median, (IQR) | 11.7 [8.5–15.4] | 12.9 [9.6–16.6] | 10.5 [6.6–10.5] | 0.011 |
| CSF WBC/µL, median, (IQR) | 188 [92-251] | 148 [67-244] | 267 [72-268] | 0.23 |
| CSF Protein, median, (IQR) | 41 [31.5-50] | 49 [23.6-68] | 25 [11-44] | 0.0001 |
| CSF Lymph%, median, (IQR) | 40 [20-50] | 35 [10-60] | 56 [20-73] | 0.0038 |
| Hypoalbuminemia at presentation, n (%) | 35 (20%) | 13 (20%) | 22 (27%) | 0.46 |
| Hypoalbuminemia at any time, n (%) | 42 (26%) | 35 (24%) | 9 (12%) | 0.24 |
| Radiographic/EEG Results, n (total %) | | | | |
| Absent, n (%) | 15/50 (30%) | 9/55 (16%) | 6/53 (11%) | 0.58 |
| Abnormal Brachial Nerve | 34/52 (65%) | 37/45 (84%) | 24/40 (60%) | 0.0001 |
| Normal Brachial Nerve | 64/69 (93%) | 45/48 (96%) | 19/20 (95%) | 0.52 |
| Outcome, n (%) | | | | |
| No seizure, n (%) | 51 (60%) | 41 (77%) | 10 (12%) | <0.0001 |
| Seizure at presentation, n (%) | 33 (36%) | 15 (24%) | 9 (11%) | 0.0001 |
| Seizure at any time, n (%) | 60 (63%) | 44 (77%) | 16 (19%) | <0.0001 |
| AMS, altered mental status; WBC, white blood cell count; ANC, absolute neutrophil count; CSF, cerebrospinal fluid; IQR, interquartile range; PMN, polymorphonuclear cells; EEG, electroencephalography; CT, computed tomography; MRI, magnetic resonance imaging. |

**Disclosures.** All Authors: No reported Disclosures.

**1876. A Hepatitis-Virus-Like Protein Is Targeted by the Antibody Response to Kawasaki Disease (KD)**

**Background.** Infection is a leading cause of admission to intensive care units (ICU), with critically ill patients often receiving a high volume of empiric broad-spectrum antibiotics. Nevertheless, a dedicated infectious diseases (ID) consultation and stewardship team is not routinely implemented. An ID-Critical Care Medicine (ID-CCM) pilot program was designed at a large tertiary hospital in which an ID attending was assigned to participate in daily rounds with the ICU team, as well as provide an ID consult on select patients. We sought to evaluate the impact of this dedicated ID consultation and stewardship program on antibiotic utilization in the ICU.

**Methods.** This is an IRB-approved single-site retrospective study. We analyzed antibiotic utilization in the ICU during the post-intervention period from January 1, 2017 to December 31, 2017 and compared it to antibiotic utilization in the same ICU during the pre-intervention period from January 1, 2015 to December 31, 2015. Using Poisson regression analysis, we evaluated antibiotic utilization of each agent, expressed as days of therapy (DOT) per 1,000 patient-days, between the two groups.

**Results.** The six most commonly used broad-spectrum antibiotic agents were included in the final analysis. During the intervention period, statistically significant reductions were seen in cefepime (131 vs. 101 DOT per 1,000 patient-days, P = 0.001), piperacillin-tazobactam (268 vs. 251 DOT per 1,000 patient-days, P = 0.002) and vancomycin (265 vs. 228 DOT per 1,000 patient-days, P = 0.01). The utilization of other antibiotics including daptomycin, linezolid, and meropenem did not differ significantly (Figure 1).

**Conclusion.** With this multidisciplinary intervention, we saw a decrease in the use of the most frequently administered broad-spectrum antibiotics. Our study shows that the implementation of an ID-CCM service is a feasible way to promote antibiotic stewardship in the ICU and can be used as a strategy to reduce unnecessary patient exposure to broad-spectrum agents.

**Disclosures.** All Authors: No reported Disclosures.

**1878. Title: Impact of Antibiotic Stewardship Rounds in the Intensive Care Setting: A Prospective Cluster-Randomized Crossover Study**

**Background.** The impact of formalized, interdisciplinary antimicrobial stewardship rounds in the ICU has eluded 50 years of study. We previously identified virus-like intracytoplasmic inclusion bodies (ICIs) in ciliated bronchial epithelium of KD children but not infant controls, but the antigens within the ICIs were unknown. At 1–2 weeks following infection, 75% of peripheral blood plasmablasts (PB) specifically target the infectious agent. We cloned the PB response to KD to identify KD-specific antibodies and their target antigens.

**Methods.** We isolated single PB from children with KD 1–3 weeks after fever onset by flow cytometry, and amplified immunoglobulin VDJ and VJ genes from each PB by flow cytometry, and amplified immunoglobulin VDJ and VJ genes from each PB by PCR.

**Results.** We sequenced 1156 PB from 11 KD patients, and identified 44 clonally expanded PB from individual patients. Mab were tested for binding to KD tissues and to a viral peptide array containing 29,939 peptides from known B cell epitopes of animal viruses (www.iedb.org).

**Conclusion.** Children with KD make antibodies to a hepacivirus-like protein, and KD ICIs contain this protein. These results strongly suggest that a previously unidentified hepacivirus with a respiratory portal of entry is etiologically related to KD.

**Disclosures.** All Authors: No reported Disclosures.

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**Figure 1. Antibiotic Utilization Rates of Most Frequently Used Broad-spectrum Agents Pre- and Post-intervention.** *Statistically significant; p = value calculated using Poisson regression analysis; DOT = Days of Therapy.

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**Disclosures.** All Authors: No reported Disclosures.