Disclosures. All authors: No reported disclosures.

1457. *Escherichia coli* Community Acquired Pneumonia
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**Background.** *Escherichia coli* has been thought to be an uncommon cause of community-acquired pneumonia (CAP). Large epidemiological data on *E. coli* CAP (E-CAP) and its comparison to *pneumococcal* CAP (P-CAP) are lacking.

**Methods.** A multi-center retrospective cohort study of adult patients (aged ≥18 years) admitted to 140 US hospitals with pneumonia and/or sepsis from 2010–2015, included in the Premier Research database. Patients with community-onset infection, antibiotic treatment beginning within the first 2 hospital days, and continued for at least 3 consecutive days were included. Patients were excluded if they had been transferred from another acute care facility, had cystic fibrosis, had a hospital length of stay of 1 day or less, co-existent urinary tract infection, gastrointestinal/ intra-abdominal infection, or simultaneous presence of another CAP pathogens. Pneumonia and sepsis were identified by ICD-9 codes.

**Results.** A total of 13,165 patients met the inclusion criteria, of which 1,247 had *E. coli* CAP. Majority of patients with E-CAP were nonnursing home residents (90.2%), 1,125/1,247, 69.3% (864/1,247) patients with E-CAP presented with ‘sepsis syndrome’ compared with only 48.1% in other Gram-negative CAP and 62.5% in P-CAP. Aspiration pneumonia was diagnosed in 5.9% (73/1,247) with E-CAP Blood cultures were positive in 59.9% (748/1,247) of patients with E-CAP with 84.8% positivity in patients with sepsis syndrome. Patients with E-CAP compared with P-CAP were more likely to require ICU-level care (42.6% vs. 38.2%), mechanical ventilation (19.3% vs. 13.8%). In-hospital mortality was 14.8% in E-CAP compared with 7.4% in P-CAP. The median cost of hospitalization was greater in E-CAP than P-CAP ($12,420.1 vs. $9,857.5) Re-admission within 30 days was greater in E-CAP compared with 7.4% in P-CAP . The median duration of anti-MRSA therapy post-INT was 23.5 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.

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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 individuals 10–14 years old 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, 84% of positive for MPP were under 5 years of age 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, 38/48 patients had radiological findings of a pulmonary infiltrate (not peripheral) with 30/38 patients (79%) had bilateral infiltrates. Admission antimicrobial therapy was the following: 8 on no antibiotic, 21 on monomicrobial and 21 on antimicrobial therapy. Mechanical ventilation was observed in 16/49 patients (32%) on the intensive care unit (ICU). Admissions occurred in 8 patients 4 direct PICU admissions and 4 patients transferred from wards to PICU. All four PICU transfers had initially nonmonomicrobial therapy; 3 of 4 were under 5 years of age.

**Conclusion.** Over half of Pediatric MPP was diagnosed by rapid molecular diagnostic tests 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 monomicrobial 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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1460. Community-Acquired Bacteremic Pneumonia in Post-pneumococcal Vaccination Era in a Pediatric Hospital
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**Background.** From January 2012 PCV13 was introduced into immunization program in Argentina, 2 ≥ 1 schedule for ≥2 years. The aims of this study were to describe epidemiological-clinical pattern of community-acquired bacteremic pneumonia (CABP) in the post-vaccination period and the risks factors of CABP occurrence, complications and lethality.

**Methods.** Cross-sectional study was performed in children with CABP diagnosis, hospitalized in Ricardo Gutierrez Children’s Hospital from January 2012 to December 2017.

**Results.** A total of 135 CABP cases were included; 63% male; 31.1% < 2 years; 75% of <5 years received PCV13; 30.4% had underlying diseases. The pathogens isolated were (n = 136): Streptococcus pneumoniae (SP) 44.9% (all susceptible to Penicillin), Staphylococcus aureus (SA) 37.5% (Methicillin-Resistant 90.2%), Haemophilus