excluded. We also excluded patients with a present on admission secondary diagnosis of cholecystitis, appendicitis, peritonitis or abdominal infections.

**Results.** A total of 95,169 patients had a diagnosis of CAP with a culture or other test performed on the first day. A pathogen was detected in 15.4% of the patients. Among the pathogen positive patients, the mean age was 67 ± 16 years (range 18–89) and 52% were male. Thirty-four percent required ICU care and 8.4% died in the hospital. Almost all patients (99%) had at least one culture drawn, including blood (96%) and respiratory (51%) specimens. Bacteria were the commonly detected pathogens. Among the Gram-positive bacteria, Streptococcus pneumoniae accounted for 22% followed by methicillin sensitive Staphylococcus aureus (MSSA), 14.4% and methicillin-resistant S. aureus (7.9%). Among the Gram-negative bacteria, the most common organisms reported were Pseudomonas aeruginosa (5.9%), Escherichia coli (5.2%) and Hemophilus influenzae (5.3%). Mycoplasma pneumoniae was identified in 2.2%. Among viral pathogens, the most common were influenza virus (2.6%) and human rhinovirus (0.7%).

**Conclusion.** In a large US inpatient sample, a majority of patients with CAP had no microbial etiology identified by laboratory testing. Among the test positive patients, S. pneumoniae was the most common bacteria reported followed by MSSA and MBSA.

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**1470. Neurocognitively-Acquiring Potentially Inappropriate Medications, Alcohol, and Community-Acquired Pneumonia Among Patients with and Without HIV**

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**Session:** 147. Respiratory Infections: CAP

**Background.** Alcohol interactions with neurocognitively-acquiring potentially inappropriate medications (NC-PIMs), and alcohol use disorders are common, more harmful, and associated with lower levels of alcohol use among people living with HIV.

**Methods.** We conducted a nested case–control study using data from the Veterans Aging Cohort Study (2007–2015). Cases with community-acquired pneumonia (CAP) requiring hospitalization (n = 6,716) were 1:5 matched to controls without CAP = 6,716) were 1:5 matched to controls without CAP. NC-PIMs (any and count overall, and by class), alcohol use disorder (AUD) diagnoses (including benzodiazepines), prescription opioids, antidepressants, antipsychotics, and muscle relaxants. Among HIV+, NC-PIMs exposure also included ritonavir (RTV), cobicistat (COBI), and efavirenz (EFV). Conditional logistic regression models were used to obtain adjusted odds ratios (OR) and 95% confidence intervals (CI) for each of the exposures. The effects of contemporaneous AUD were used to obtain adjusted odds ratios (OR) and 95% confidence intervals (CI) for each of the exposures. The effects of contemporaneous AUD.

**Results.** Among HIV+, NC-PIMs exposure also included ritonavir (RTV), cobicistat (COBI), and efavirenz (EFV). Conditional logistic regression models were used to obtain adjusted odds ratios (OR) and 95% confidence intervals (CI) for each of the exposures. The effects of contemporaneous AUD were used to obtain adjusted odds ratios (OR) and 95% confidence intervals (CI) for each of the exposures. The effects of contemporaneous AUD.

**Conclusion.** Among HIV+, all classes of NC-PIMs (any and count overall, and by class), alcohol use disorder (AUD) diagnoses (including benzodiazepines), prescription opioids, antidepressants, antipsychotics, and muscle relaxants were associated with increased CAP risk among those living with and without HIV.

**Disclosures.** All authors: No reported disclosures.

**1471. Case Report: Andes Virus Hantavirus Pulmonary Syndrome in a Traveler Returning to the United States**

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**Session:** 148. Respiratory Infections: Miscellaneous

**Background.** Andes virus (ANDV), a New World hantavirus, is transmitted to humans via contact with the long-tailed spiny rodent rice rat (Oligoryzomys longicaudatus) in Chile and Argentina. Unlike other hantaviruses, ANDV can be transmitted person-to-person. It has a case mortality rate of approximately 30%. Here we describe the first known importation of ANDV to the United States.

**Methods.** On January 9, 2018, a 29-year-old female with no significant past medical history returned to the United States from a 3-week group trip to Chile and Argentina. She did not receive vaccines or take prophylaxis. She visited Central California before returning to Delaware. January 19 she presented with fevers, vomiting, and extreme fatigue. Examination was remarkable for hypotension requiring fluid resuscitation and O2 saturation of 89% on room air. She described chest tightness, dyspnea, influenza, community-acquired pneumonia, and PE were considered. Sputum influenza A/B and RSV PCR were negative. Laboratories revealed hypoalbuminemia at 2.2 g/dL, thrombocytopenia at 61,000, and transaminisAT 342 and ALT 302. Peptides were within normal range with maximum of 11,000. Computerized tomography (CT) of chest revealed bilateral lower lobe ground-glass opacities, pleural effusions, and pulmonary edema. She was started on antibiotics. Her symptoms continued. She developed blurred vision and peri-orbital edema. She required 3 L O2, nasol cannula. She required 3 L O2, nasol cannula. She was transferred to a tertiary care center where she required 3 L O2, nasol cannula. She was transferred to a tertiary care center where she developed dyspnea, hypotension, and severe hypoxia. She was transferred to a tertiary care center where she developed dyspnea, hypotension, and severe hypoxia. She was transferred to a tertiary care center where she developed dyspnea, hypotension, and severe hypoxia.

**Results.** She was discharged Day 6 after resolution of fever, hypoxia and thrombocytopenia.

**Disclosures.** All authors: No reported disclosures.

**1472. Antibiotic De-escalation Compared with Continued Empirical Treatment in Non-Ventilated Hospital-Acquired Pneumonia**

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**Session:** 148. Respiratory Infections: Miscellaneous

**Background.** Antibiotic de-escalation is an important component of antimicrobial stewardship programs. Nosocomial pneumonia is the most common healthcare-associated infection with ventilated hospital-acquired pneumonia (HAP) comprising the majority of cases. We aimed to compare antibiotic de-escalation with continued empirical treatment in terms of clinical outcomes in nonventilated HAP.

**Methods.** A retrospective cohort study was conducted including patients meeting the American Thoracic Society criteria for HAP. This compared de-escalated HAP patients to those continued on empirical treatment across three hospitals in West London over 3 months. The primary outcome was the length of stay (LOS), and secondary outcomes were duration of treatment and cost of hospital stay. Effects were adjusted for confounders using multivariate linear regression models.
Results. Eighty patients with HAP were identified. Overall, 22/80 (27.5%) had therapy de-escalated and 47/80 (58.8%) continued empirical treatment. A total of 58 patients survived and were included in the analysis, 20 in de-escalation and 38 in continued empirical treatment. Length of stay was shorter in de-escalation by −7.2 (95% CI −12.2, −1.0) days, P < 0.01, with an adjusted difference of −3.2 (95% CI −8.3, 1.9) days, P = 0.21. The duration of treatment was shorter in de-escalation by −3.4 (95% CI −5.8, −0.9) days, P < 0.01, with an adjusted difference of −2.6 (95% CI −5.2, 0.1) days, P = 0.06. The cost of hospital stay was lower in de-escalation by €−2, 907.37 (95% CI −4,865.31, −949.43), P < 0.01, with an adjusted difference of €−1,290.00 (95% CI −3,320.75, 740.74), P = 0.21.

Conclusion. In HAP 27.5% of patients were de-escalated. There was no difference in LOS, duration of treatment, and cost of hospital stay between de-escalation and continued empirical treatment on adjustment for confounders. Future work should explore the relationship between de-escalation and antimicrobial resistance in HAP.

Disclosures. All authors: No reported disclosures.

Figure 1:

![Figure 1](image1.png)

Figure 2. (MTB, Mycobacterium tuberculosis; NTB, non-Mycobacterium tuberculosis)

Disclosures. All authors: No reported disclosures.

1475. Etiology and Outcome of Fever and Respiratory Distress in Adult Patients Presenting to Medical Emergency in a Tertiary Care Hospital in North India

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Session: 148. Respiratory Infections: Miscellaneous

Friday, October 5, 2018: 12:30 PM

Background. To study the region-specific etiology and outcome in adult patients with acute febrile illness and ARDS.

Methods. Prospective observational study done among 102 adult patients admitted to a medical emergency, PGIMER, during study interval of 18 months (January 2016 to June 2017), with acute febrile illness (oral temperature more than 101°F for less than 14 days with no localising symptoms) and ARDS (acute onset respiratory distress within one week of fever or new/worsening respiratory symptoms with bilateral opacities on chest radiograph, symptoms not explained by cardiac failure or fluid overload with PaO2/FiO2 ratio <300 with PEEP or CPAP >5 cm H2O). All patients were investigated for the etiology as per standard protocol for malaria, scrub typhus, Leptospirosis, enteric fever, dengue, H1N1 influenza. Patients were followed till discharge or 28th day whichever is longer.

Results. Among the 102 patients recruited in the study, 41.2% were males and 58.8% were females. Mean age of presentation was 38.06±17.26 years. 46% of patients admitted during post monsoon season. 26.5% patients had succumbed to their illness. Cough (61.8%), hepatomegaly (50%), myalgia (50%), splenomegaly (30.3%),