inappropriate empiric BSA treatment had higher readmissions 30 days after discharge, more transfers to the intensive care unit, more antibiotic-associated adverse events, and longer hospitalizations (Fig. 2). **Conclusions:** Patients hospitalized with CAP often received inappropriate BSA as empiric coverage, and this inappropriate antibiotic selection was associated with worse patient outcomes. To improve patient outcomes, stewardship efforts should focus on reducing inappropriate BSA use in patients hospitalized for CAP with historic HCAP risk factors or severe CAP without other guideline-directed indications for BSA.

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Effect of antifungal stewardship on micafungin prescribing practices in intensive care units at a tertiary-care hospital

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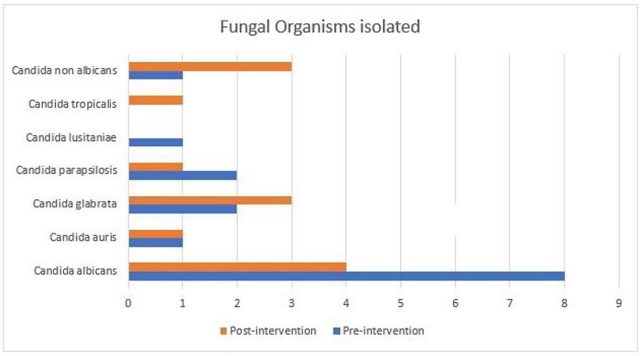
Background: Fungal diseases are associated with substantial global mortality and economic burden, especially in critically ill or immunocompromised patients. Antifungal resistance has emerged as a barrier to treating invasive fungal infections, but antifungal stewardship is still a developing effort due to limited data. Here, we describe the antifungal prescribing practices and the impact of antifungal stewardship on micafungin days of therapy (DOTs) in critical care units. **Methods:** This retrospective study included patients who were admitted to the intensive care unit (ICU) at a tertiary-care hospital in Washington, DC. The preintervention group included baseline micafungin use data between January 1, 2021, and May 31, 2021. The postintervention group included prospective audits, feedback on micafungin orders by a clinical pharmacist, and education on the appropriateness of the antifungal agents. The postintervention group included patients admitted between June 1, 2021, and December 31, 2021. Approval was obtained from the institutional review board. **Results:** The overall average of micafungin days of therapy (DOT) per 1,000 patient days present in the preintervention group versus the postintervention group was 33 versus 24 days, respectively. Moreover, 121 patients were randomly selected for a more detailed retrospective review to define micafungin prescribing practices further. Of these, 73 patients (60.3%) were male; the median age was 63 years. The most common cause for prescribing micafungin in both groups was empiric antifungal coverage (62.8%), followed by fungemia (12.4%). The most common organism isolated was *Candida albicans*. For other sources of infection and organisms isolated, refer to Table 1. In-hospital mortality occurred in 63 (52.06%) patients in both groups. **Conclusions:** Antifungal stewardship through prospective audit and feedback and education by clinical pharmacists decreased micafungin DOTs in critical care units. Empiric prescribing of micafungin is highly prevalent in the ICU despite the low incidence of invasive fungal infections. Although periodic drug utilization reviews and pharmaceutical surveillance can help reduce the prolonged duration of micafungin therapy in the ICU, more robust and routine antifungal stewardship is key to the appropriate use of micafungin to avoid the emergence of antifungal resistance.



	All patients	Pre-intervention	Post-intervention
Total no. of patients	121	58	63
Sex, n (%)			
Male	73(60.3)	37(63.7)	36(57.1)
Female	48(39.7)	21(36.3)	27(42.8)
Race, n (%)			
African American	88(72.7)	44(75.8)	44(69.8)
Caucasian	23(19)	11(18.9)	12(19)
Hispanic	4(3.3)	1(1.7)	3(4.7)
Other	6(4.9)	2(3.4)	4(6.3)
Age, Years, Median	63	62	63
Median BMI (kg/m^2)	27.53	28.37	27.35
Comorbities, n (%)			
Diabetes	39(32.2)	17(29.3)	22(34.9)
HIV	5(7.9)	3(5.1)	2(3.2)
Cancer			
Active Cancer	20(16.5)	10(17.2)	10(15.8)
H/o Cancer	4(3.3)	2(3.4)	2(3.2)
On Immunosuppression	20(16.5)	10(17.2)	10(15.8)
Trauma	6(4.9)	3(5.1)	3(4.8)
In house mortality, n (%)	63(52.1)	35(60.1)	28(44.4)
Infection Source, n (%)			
Empiric	76(62.8)	41(70.6)	35(55.5)
Fungemia	15(12.4)	8(13.8)	7(11.1)
Cardiac device	1(0.8)	0	1(1.6)
Abdominal	14(11.6)	4(6.9)	10(15.8)
SSTI	5(4.1)	1(1.7)	4(6.3)
IV catheter/vascular graft	13(10.7)	8(13.8)	5(7.9)
Endocarditis	0	0	0
Osteomyelitis	1(0.8)	1(1.7)	0
Other[a]	9(7.4)	3(5.1)	6(9.5)

a: Including head and neck infections, antifungal prophylaxis etc.

Table 1: Demographic and Microbiological data

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Serotonergic agents and linezolid: Impact of exposure to more than one agent concomitantly on risk of adverse effects

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Background: The off-target effects linezolid have the potential to cause serotonin syndrome when given in conjunction with serotonergic agents. Despite package insert labeling as a contraindication, several postmarketing studies have demonstrated a low incidence of serotonin syndrome with the concomitant use of linezolid and other serotonergic agents. Linezolid provides a convenient oral option for gram-positive infections. However, due to concerns for serotonin syndrome, the use of linezolid is sometimes avoided. **Methods:** We performed a single-center, retrospective, medical record review of all adult inpatients from September 2021 to September 2022. Patients included had 1 administration of linezolid and 1 inpatient administration of a selective serotonin reuptake inhibitor (SSRI) or serotonin and norepinephrine reuptake inhibitor (SNRI) within 14 days. The primary outcome was the incidence of serotonin