required antipseudomonal coverage, if therapy was required due to allergies, or if they had neutropenic fever. The primary outcome was de-escalation, defined as discontinuation or narrowing of antipseudomonal therapy, within 24 hours of the finalized respiratory culture report. Secondary outcomes included duration of therapy, hospital length of stay, Clostridioides difficile infection within 30 days, and in-hospital mortality. Outcomes were compared in pre- and post-intervention cohorts. **Results:** Of 230 screened patients, 175 met the inclusion criteria (107 pre-intervention, 68 post-intervention). Approximately one-third of subjects had community-acquired pneumonia(34 in pre-intervention and 28 in post-intervention). Baseline characteristics suggested the pre-intervention cohort had higher severity of illness, with more ICU admissions (N =68 in pre-intervention and N=28 in post intervention) and more hospital-acquired (N= 21in pre and N=8 in post) or ventilator-associated pneumonia (N=7 in pre, N=2 in post). De-escalation within 24 hours occurred in (76) 71% of pre-intervention patients and (50) 73.5% post-intervention (p=0.72). Median duration of antibiotics after final culture result was 1 day (IQR, -1,3) in the pre-intervention group and 0 days (IQR, -2,3) in the post-intervention group (P=0.36). Median hospital length of stay was significantly longer in the pre-intervention group (IQR 13(6,20) vs 9 (5,16); p=0.03). Rates of C. difficile infection (<5%) and in-hospital mortality did not differ significantly between groups. **Conclusion:** Implementation of a microbiology nudge comment in respiratory culture result reporting did not significantly increase antipseudomonal antibiotic de-escalation. High rates of de-escalation were observed even prior to the intervention. Explanations for the finding may be that respiratory cultures are being sent unnecessarily and, therefore, they are not being used as data to act upon and/or anti-pseudomonal antibiotics are being started empirically unnecessarily, particularly in patients with CAP. The cohorts did differ in severity of illness, which may have impacted the results. These findings highlight the need for additional education regarding guideline-directed respiratory culture utilization and empiric antibiotic choices.

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Presentation Type:
Poster Presentation
Subject Category: Antibiotic Stewardship

Changes in Antibiotic Consumption Following Reimplementation of an Antimicrobial Stewardship Program after Temporary Suspension‡

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Background: In early 2024, a nationwide healthcare system disruption in South Korea led to temporary suspension of the antimicrobial stewardship program (ASP) at a tertiary care center due to critical workforce shortages, which was accompanied by increased use of antibiotics, particularly restricted agents. In November 2024, a national ASP pilot program enabled reimplementation of ASP activities. We evaluated changes in hospital-wide antibiotic consumption following ASP reimplementation. Methods This retrospective, single-center study evaluated hospital-wide antibiotic use from March 2024 to November 2025 at a 2,446-bed tertiary care center (Asan Medical Center, Seoul). Antibiotics were classified as restricted agents subject to ASP interventions (preauthorization and prospective audit and feedback) and nonrestricted agents without such interventions. Changes in monthly days of therapy (DOT) per 1,000 patient-days were analyzed using interrupted time-series analysis, with November 2024 defined as the intervention time point. Results Over a 21-month study period, a total of 1,070,544 patient-days were included. Following reimplementation of the ASP, interrupted time-series analyses showed a reduction in total antibiotic use, corresponding to a 7.9% relative decrease (95% CI, 12.6% to −2.2%). This overall change was driven primarily by restricted antibiotics, which demonstrated significant reductions in both level (−29.8 DOT per 1,000 patient-days; 95% CI, 50.6 to −9.05; P = .012) and trend (−5.03 DOT per 1,000 patient-days per month; 95% CI, −7.65 to −2.41; P = .0015), yielding a 29.7% relative reduction (95% CI, −36.0% to −21.8%) compared with projected counterfactual use. In contrast, nonrestricted antibiotics showed no statistically significant changes. Conclusion Although reductions in restricted antibiotic use following ASP implementation are well recognized, our findings demonstrate that stewardship effects can be effectively restored after temporary program interruption. This resilience underscores the role of antimicrobial stewardship as a system-level safeguard against inappropriate antibiotic escalation, particularly in the context of healthcare system disruptions.

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Table 1. Changes in monthly antibiotic use before and after ASP reimplementation

Variable	Mean before ASP reimplementation (DOT/1,000 PD)	Mean after ASP implementation (DOT/1,000 PD)	Observed percent change* (%)
Total antibiotics	868	847	−2.3
Restricted	163	147	−9.8
Non-restricted	705	700	−0.6
Patient-days†	47,817	52,923	10.6

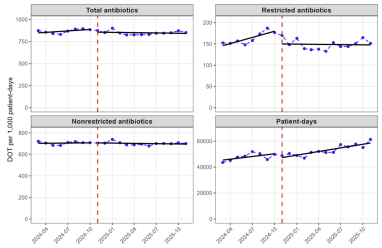
DOT, days of therapy; PD, patient-days
* Percent change was calculated as the percentage difference between the mean value after ASP reimplementation and the mean value before suspension using the formula, [(mean after − mean before)/mean before] × 100.
† Patient-days are presented as absolute counts, not normalized per 1,000 patient-days.

Table 2. Association of ASP reimplementation with monthly DOT per 1,000 patient-days

Antibiotic group	Baseline trend		Level change		Trend change		Relative change* (%) (95% CI)
	Coefficient (95% CI)	P-value	Coefficient (95% CI)	P-value	Coefficient (95% CI)	P-value	
Total	5.51 (−0.17 to 11.2)	0.08	−29.2 (−65.30 to 6.95)	0.13	−6.65 (−13.2 to −0.08)	0.06	−7.9 (−12.6 to −2.2)
Restricted	4.85 (2.92 to 6.78)	**<0.001**	−29.8 (−50.6 to −9.05)	**0.012**	−5.03 (−7.65 to −2.41)	**0.0015**	−29.7 (−36.0 to −21.8)
Non-restricted	0.66 (−3.49 to 4.81)	0.76	0.65 (−21.8 to 23.1)	0.96	−1.62 (−6.21 to 2.97)	0.49	−1.5 (−6.0 to 3.9)

* Relative change (%) was derived by comparing observed DOTs with model-estimated counterfactual values assuming continued ASP suspension. Statistically significant p-values are indicated in bold. DOT, days of therapy; CI, confidence interval.

Figure 1. Changes in antibiotic use before and after ASP reimplementation



Each panel represents days of therapy (DOT) per 1,000 patient-days for a specific antibiotic category: total antibiotics, restricted antibiotics, and non-restricted antibiotics. The red dashed vertical line indicates the reimplementation of the ASP in November 2024. The solid black lines represent the fitted linear regression lines before and after ASP reimplementation.

Presentation Type:
Poster Presentation
Subject Category: Antibiotic Stewardship

Impact of Direct Provider Feedback on Ambulatory Antibiotic Duration for Pneumonia and Skin and Soft Tissue Infection‡

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Background: Antimicrobial overuse increases antimicrobial resistance and adverse effects. Most antibiotics are prescribed in the ambulatory setting and up to half are inappropriate. We investigated the effect of a bundled stewardship intervention with active audit and feedback on antibiotic duration for two common infections, community acquired pneumonia (CAP) and skin and soft tissue infection (SSTI), in adult outpatients. **Methods:** From 2019-2021, institutional guidelines for management of CAP and SSTI were developed, and a dashboard to passively report data

‡The abstract titles in this supplement have been corrected since original publication. A notice detailing the changes has been published at https://doi.org/10.1017/ash.2026.10802.

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