Methods. MCDU data from the National Center for Health Statistics (NCHS) for the years 1990–2015 were analyzed. Mortality rates and 95% confidence intervals (CI) were calculated for age, sex, race/ethnicity, year, and state. Poisson regression models were used to examine temporal trends. Logistic regression was used to determine whether selected comorbid conditions were associated with salmonellosis-related deaths. Over a 2-year period at a University Hospital, the GI panel only had a positive result for C. difficile in the first 48 hours after admission, 22% were ordered after 48 hours, after which etiologies of hospital-onset diarrhea are expected to be more common. Among all GI Panel tests ordered, C. difficile was the most common organism identified, followed by Norovirus. Each of these organisms has an accurate and less costly alternative test. Stand-alone testing for C. difficile and Norovirus should be considered prior to the GI Panel for patients admitted to the hospital, particularly when admitted >48 hours.

Disclosures. All authors: No reported disclosures.

1488. Effects of Clostridium difficile Infection in Hospitalized Patients with Inflammatory Bowel Disease, National Inpatient Sample Study 2016

Background. Patients with inflammatory bowel disease (IBD) including ulcerative colitis (UC) and Crohn’s disease (CD) have been shown to have increased Clostridium difficile infection (CDI) rates. In this study, we aimed to determine the effects of concurrent CDI in the outcomes of hospitalized patients with IBD.

Methods. In this retrospective cohort study, we analyzed the 2016 National Inpatient Sample (NIS) database of hospitalized patients with a first or secondary diagnosis of IBD and CDI using their respective ICD-10 codes. Primary outcomes of interest were all-cause mortality, hospital length of stay, total cost for hospital stay, and rate of colectomy. Multivariate regression was used to adjust for age, gender, race, hospital bed size, and Charlson comorbidity index. We used STATA version 14 for analysis.

Results. There were a total of 3,306 patients admitted with IBD and CDI, of which 1,864 had a diagnosis of UC and 1,460 had a diagnosis of CD. 58.02% of the cases were female and the mean age was 52.5 years old. The mean age of patients in the CD group (48.97 [47.79–50.15]) was lower than the UC group (55.16 [54.01–56.31]). The results of in-hospital outcomes are shown in Tables 1 and 2.

Conclusion. We observed a significant increase in all-cause mortality, hospital length of stay, and total cost for hospital stay in IBD patients with concurrent CDI.

Disclosures. All authors: No reported disclosures.

1489. Vancomycin 125 mg vs. 250 mg for the Treatment of Non-Severe and Severe Clostridium difficile Infections

Background. Infectious Diseases Society of America (IDSA) guidelines recommend oral vancomycin 125 mg four times daily for 10 to 14 days for both non-severe and severe C. difficile infections (CDI). Although 125 mg achieves sufficient fecal concentrations, doses of 250 mg are still commonly used in practice. There is limited data available comparing vancomycin 125 mg to higher doses. To the best of our knowledge, there are no studies that compare the effectiveness of vancomycin 125 mg vs. 250 mg in the treatment of CDI.

Methods. Single-center, retrospective cohort analysis of oral vancomycin 125 mg vs. 250 mg for the treatment of CDI between June 2018 and February 2019. Diagnosis of CDI involved symptomatic patients with positive Clostridium difficile toxin by either polymerase chain reaction or toxin enzyme immunoassay. We used IDSA guideline criteria of severe and non-severe to evaluate those who received a 10- or 14-day course of oral vancomycin. We excluded patients with concomitant metronidazole or fidaxomicin use, history of CDI in the past 8 weeks, fulminant CDI, or mortality prior to completion of therapy. The primary outcome was resolution of clinically significant diarrhea. Secondary outcomes included duration of loose stools, relapse of CDI within 30 days of diagnosis, and 30-day all-cause mortality.

Results. A total of 93 patients were included in the study, with 71 patients (76.3%) in the 125 mg group and 22 patients (23.7%) in the 250 mg group. Both groups were well matched with no significant differences at baseline or during treatment. Results showed no statistical difference in clinical resolution between the 125 mg and 250 mg groups, with 70 patients (98.6%) and 22 patients (100%) achieving clinical resolution, respectively (P = 1.00). Secondary outcomes revealed no statistical difference in duration of symptoms, relapse, or 30-day all-cause mortality.

Conclusion. There was no difference in clinical resolution of CDI between the vancomycin 125 mg and 250 mg groups. Furthermore, the dose of vancomycin did not have a significant effect on duration of symptoms, relapse, or 30-day all-cause mortality. Using the lower, guideline-recommended dose of vancomycin could potentially reduce patient exposure and provide cost-savings benefits without sacrificing efficacy.

Disclosures. All authors: No reported disclosures.