the likelihood of testing that did not differ significantly between specialties included patient history of travel to a high-risk area (75% Peds, 71% FP 72% GIM), immunocompromised patient (Peds 67%, FP 60%, GIM 69%), and clinical suspicion of a pathogen that can be treated with antibiotics or antiparasitics (Peds 63%, FP 56%, GIM 65%).

Factors with significant differences between specialties that were most often reported as greatly increasing likelihood of testing included presence of blood in stool (Peds 76%, FP 58%, GIM 48%, P < 0.0001), history of recent antibiotic use (Peds 31%, FP 66%, GIM 72%, P < 0.0001), history of recent hospitalization (Peds 29%, FP 61%, GIM 64%, P < 0.0001), consideration of inpatient admission (Peds 36%, FP 57%, GIM 56%, P < 0.0001), and fever ≥38.5 °C (Peds 13%, FP 27%, GIM 40%, P < 0.0001). Factors most often reported as greatly decreasing the likelihood of testing included presence of vomiting without diarrhea (Peds 49%, FP 43%, GIM 50%) and presence of vomiting and diarrhea together (Peds 12%, FP 7%, GIM 9%).

**Conclusion.** Physicians rely on a variety of factors when considering diagnostic testing for stool pathogens in AGE, with recent travel, caring for an immunocompromised patient, and antibiotic/antiparasitic treatment decisions often reported as increasing the likelihood of testing. Consideration of the clinical presentation and most common AGE pathogens by age group may drive some of the differences between specialties.

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

### 1110. A Multicenter Evaluation of Outcomes Associated With Oral Vancomycin Dose in Patients With Clostridium difficile Infection

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**Session:** 133. Enteric Infections

**Friday, October 5, 2018: 12:30 PM**

**Background.** *Clostridium difficile* infection (CDI) is a significant cause of morbidity and mortality. IDSA guidelines recommend oral vancomycin (VAN) for the treatment of CDI, although doses used in practice vary substantially. The purpose of this study was to determine differences in outcomes between patients treated with high dose (HD; ≥250 mg four times daily [QID]) vs. standard dose (SD; 125 mg QID) VAN for CDI.

**Methods.** This multicenter study evaluated patients at two hospitals in Albany, NY diagnosed with CDI and treated with oral VAN between January 2013 and August 2017. Hospitalized patients were included if: age 21 years, positive *C. difficile* toxin polymerase chain reaction (PCR), symptomatic infection (e.g., new onset or increased frequency of loose stools), and received 248 hours of VAN therapy. Patients were excluded if: received ≥248 hours of metronidazole prior to VAN initiation, VAN per rectum, required surgical intervention ≤48 hours from PCR, had a history of fecal microbiota transplant, received ≥2 dose of fidaxomicin or tigecycline prior to or within 48 hours from PCR, or died ≤48 hours from PCR. The primary outcome was 90-day CDI recurrence; secondary outcomes included 30-day all-cause mortality and 90-day readmission.

**Results.** Four hundred fifty-eight patients were included (site 1: 270; site 2: 188). Two hundred twenty-four patients received SD VAN (48.9%); 234 received HD VAN (250 mg QID: 199 [43.5%]; 500 mg QID: 35 [7.6%]). Baseline demographics were similar between groups. Patients treated with HD were more likely to present with colitis (19.2% vs. 29.5%, P = 0.01) and have higher infection severity based on ISDA (P < 0.01). Zaf (P < 0.01), and American College of Gastroenterology (P < 0.02) criteria. Modified APACHE II scores were similar between SD and HD groups (median: 12.2 vs. 12.9, P = 0.17). MV analysis identified no difference in 90-day recurrence with HD (OR 1.65, 95% CI 0.96–2.87) and MM analysis identified no difference in 90-day recurrence with HD (OR 1.49, 95% CI 0.89–2.51). Secondary outcomes of 30-day all-cause mortality and 90-day readmission did not differ significantly between groups.

**Conclusion.** No differences in recurrence, mortality, or readmission were identified between SD and HD ORAL VAN for the treatment of CDI, though HD VAN patients primarily received 250 mg QID.

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### 1112. Detection of Enteric Viruses in Children With Acute Gastroenteritis

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**Session:** 133. Enteric Infections

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**Background.** Acute gastroenteritis (AGE) is a major cause of morbidity in children. Viral pathogens are the most common infectious agents. Differences in illness characteristics of AGE and with and without virus detection are poorly defined. We compared AGE illness characteristics between children with and without any-virus detected, and with single vs. multiple viruses detected.

**Methods.** Children between 15 days and 17 years of age defined as diarrhea (>3 loose stools/24 hours) or any vomiting within 10 days duration were enrolled in Vanderbilt Children’s Hospital inpatient, ED, and outpatient settings from December 2012 to November 2015. Stool specimens were tested by RT-qPCR for norovirus, sapovirus, and astrovirus and by ELISA (VP6 antigen [Rotacline ™] for rotavirus.

**Results.** Of 3,705 children enrolled, 2,892 (78%) specimens were collected. A single virus was detected in 1,109 (38%) stools [51% norovirus, 20% rotavirus, 21% sapovirus, and 8% astrovirus], viral co-detected were found in 115 (4%) stools, and 1,665 (58%) had no detected viruses. Table 1 compares children with and without any-virus detected. Children with a single-virus detected were older than those with >1 virus detected (1.8 vs. 1.5 years [P < 0.05]) with no other significant differences.

**Table 1.**

| Virus Detected | No-Virus Detected | Any-Virus Detected | P-value |
|----------------|-------------------|--------------------|--------|
| Age (years)    | 2.0 (2.79–5.65)   | 1.8 (0.96–4.00)    | 0.21   |
| Diarrhea       | 1102 (66.2%)      | 891 (72.8%)        | <0.01  |
| Max. no. diarrhea stools/24 hours | 5 (3–7) | 5 (3–7) | 0.30 |
| Vomiting       | 1298 (78.1%)      | 1101 (89.9%)       | <0.01  |
| Max. no. vomiting episodes/24 hours | 3 (2–6) | 4 (3–7) | <0.01 |
| Fever          | 1112 (66.8%)      | 690 (56.4%)        | <0.01  |
| Max. temperature | 102 (101–103)*  | 101 (100–103)*     | <0.01  |
| Sick contact   | 447 (26.9%)       | 429 (35.1%)        | <0.01  |
| Modified Vesikari Score (MV3) | 6 (4–8)* | 7 (5–9)* | <0.01 |
| Days of illness | 2 (2–4)* | 2 (1–4)* | 0.01 |

Data are in n (%).

*Median (IQR).

**Conclusion.** Children with any-virus detected had more severe symptoms, higher MV, and more frequently reported sick contacts compared with no-virus detected. Children with no-virus detected were more likely to present with fever and higher...
111. Use of a Fluoroquinolone (FQ) vs. a Non-Fluoroquinolone (Non-FQ)-Based Antibiotic Regimen in the Treatment of Acute, Uncomplicated Diverticulitis Jessyca Mourani, PharmD; Michael Postelnick, RPh BCPS AQ ID2 and David Martin, PharmD, BCPS; 1Pharmacy, Northwestern Memorial Hospital, Chicago, Illinois, 2Department of Pharmacy, Northwestern Medicine, Chicago, Illinois.

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Background. The management of acute, uncomplicated diverticulitis (DVT) remains based on expert consensus rather than on evidence from randomized clinical trials. The most common antibiotic (AB) regimen used in this patient population is metronidazole plus a fluoroquinolone (FQ). Non-FQ options, including B-lactam and metronidazole regimens are available. Since there is a lack of clinical data comparing outcomes between these regimens, it remains uncertain whether patients presenting with acute, uncomplicated DVT require a FQ-based regimen. Increasing rates of FQ resistance and awareness of collateral damage have raised concern about whether this class should remain a first-line option.

Methods. This retrospective cohort study was conducted utilizing electronic health records to identify patients 18 years of age or older with acute, uncomplicated DVT, defined by ICD 10 codes. Patients included had CT confirmed DVT and were started on a guideline recommended AB regimen. Data points collected included length of stay, 30-day readmission due to DVT, time to conversion from IV to PO AB, progression to surgery, and discharge AB regimen. The primary objective is to evaluate differences in length of stay and 30 day re-admission rates. The secondary objectives are to evaluate time from intravenous (IV) to oral (PO) AB, progression to surgery, and discharge AB between the two groups.

Results. 136 patients were evaluated, 71 FQ and 65 non-FQ. Length of stay was 4 days (1–18) in the FQ group vs. 5 days (1–19) in the non-FQ group (P = 0.236). 11% of patients in the FQ group vs. 9% of patients in the non-FQ group had a DVT related complication (IV to oral conversion: P = 0.451). 10% of patients in the FQ group vs. 23% of patients in the non-FQ group progressed to GI surgery during the admission. Time from IV to PO conversion of AB was 34.2 hours (0–63) in the FQ group vs. 48.4 hours (0–81) hours in the non-FQ group. Lastly, 63 of the 71 patients who were started on a FQ were discharged on an oral FQ vs. Forty patients of the 65 patients started on a non-FQ were discharged on an oral FQ.

Conclusion. In the treatment of acute, uncomplicated DVT outcomes including length of stay, 30-day readmission, time from IV to PO AB, and progression to surgery were comparable in patients receiving treatment with a FQ based AB regimen vs. a non-FQ based regimen.

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