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% GM), immunocompromised patient (Peds 68%, FP 65%, GM 69%), and clinical suspicion of a pathogen that can be treated with antibiotics or antiparasitics (Peds 63%, FP 56%, GM 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%, GM 48%, \(P < 0.0001\)), history of recent antibiotic use (Peds 31%, FP 66%, GM 72%, \(P < 0.0001\)), history of recent hospitalization (Peds 29%, FP 61%, GM 64%, \(P < 0.0001\)), consideration of inpatient admission (Peds 36%, FP 57%, GM 56%, \(P < 0.0001\)), and fever ≥38.5 °C (Peds 13%, FP 27%, GM 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%, GM 50%) and presence of vomiting and diarrhea together (Peds 12%, FP 7%, GM 9%).

**Conclusions.** 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.

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

Monika Bidell, PharmD, BCPS,1; Gregory Novak, PharmD;2; Gurkarat Singh, Pharmacology, PharmD;2; Benjamin Bratek, BS, AAS, RN;1; Odirschuworu Dursu, PharmD Candidate;1; Colby Mitchell, PharmD;2 and J Nicholas O’Donnell, PharmD, MSc;2; Pharmacy Practice, Albany College of Pharmacy and Health Sciences, Albany, New York, 1St. Peter’s Hospital, Albany, New York, 2Albany Medical Center, Albany, New York

**Session:** 133. Enteric Infections

**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 244 hours of VAN QID. Patients were excluded if: received 244 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 doses 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. Variables with a P-value <0.2 in univariate analysis were evaluated in multivariate (MV) analyses.

**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 specialties.

**Conclusions.** No differences in recurrence, mortality, or readmission were identified between SD and HD 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

Lubna Hamdan, MD;1 Einat Batarseh, MD;2 Bhnhata Piyu, MPH;1; Laura Stewart, PhD;1; Chris Fennesbeck, PhD2; James D. Chappell, MD, PhD;1; Daniel C. Payne, PhD, MSPh;1; Aron J. Hall, DVM, MSPh;1; John Dunn, DVM, PhD;3; Mary E. Wilkswo, MPH1 and Natasha Halasa, MD, MPH,1; Vanderbilt University Medical Center, Nashville, Tennessee, 2Biostatistics, Vanderbilt University, Nashville, Tennessee, 3Centers for Disease Control and Prevention, Atlanta, Georgia, 4Division of Viral Diseases, Centers for Disease Control and Prevention, Atlanta, Georgia, 5Division of Communicable and Environmental Diseases and Emergency Preparedness, Tennessee Department of Health, Nashville, Tennessee

**Session:** 133. Enteric Infections

**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 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 with 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 [Rotacide]) 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-detections 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.**

|                      | No-Virus Detected (n = 1,665) | Any-Virus Detected (n = 1,224) | Pvalue |
|----------------------|-------------------------------|--------------------------------|--------|
| Age (years)          | 2 (0.79–5.65a)                | 1.8 (0.96–4.00a)                | 0.21   |
| Diarrhea             | 1102 (62.6%)                  | 891 (72.8%)                    | <0.01  |
| Max. no. of diarrheal stools/24 hours | 5 (3–7)*               | 5 (3–7)*                       | 0.30   |
| Vomiting             | 128 (68.1%)                   | 1101 (89.9%)                   | <0.01  |
| Max. no. of vomiting episodes/24 hours | 3 (2–5)*                  | 4 (3–7)*                       | <0.01  |
| Fever                | 1112 (66.8%)                  | 690 (56.4%)                    | <0.01  |
| Maximum temperature  | 102 (101–103a)                | 101 (100–103a)                 | <0.01  |
| Sick contact         | 447 (26.9%)                   | 429 (35.1%)                    | <0.01  |
| Modified Vesikari Score (MV5) | 6 (4–8)*                 | 7 (5–9)*                       | <0.01  |

**Data are in n (%).**
aMedian (IQR).

**Conclusion.** Children with any-virus detected had more severe symptoms, higher MV5, 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