Background. Patients undergoing treatment for hematologic malignancy are at a higher risk for developing Clostridium difficile infection (CDI). We sought to determine the incidence of toxigenic C. difficile (TCD) carriage and CDI incidence among patients undergoing with newly diagnosed or relapsed acute leukemia.

Methods. Serial stool samples were collected from 92 patients with new or relapsed acute leukemia at Memorial Sloan Kettering Cancer Center between August 26, 2011 to January 22, 2013. Only the first hospitalization during this time period was included. Screening was performed by toxigenic culture and PCR amplification using primers of TCD genes.

Results. As rates of CA CDI increase, clinicians should be aware of rates of infection following administration of common antibiotics. The most common antibiotics to cause CA CDI were third-generation cephalosporins (ceftriaxone and cefdinir) and ciprofloxacin.

Conclusions. As rates of CA CDI increase, clinicians should be aware of rates of infection following administration of common antibiotics. The most common antibiotics to cause CA CDI were third-generation cephalosporins (ceftriaxone and cefdinir) and ciprofloxacin.

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1280. Increasing Economic Burden of Inpatient Clostridium difficile Infection in the United States: National Trends in Epidemiology, Outcomes, and Cost of Care from 2000 to 2014
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Session: 149. HAI: C. difficile Epidemiology, Impact, and Testing
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Background. There is limited data addressing the epidemiology, costs, and outcomes of C. difficile infection (CDI) in hospitalized patients in the United States (U.S.). This study aims to estimate the characteristics, outcomes, and economic burden of patients hospitalized for CD in the US.

Methods. The Nationwide Inpatient Sample (NIS) database was used to obtain data from 2000–2014. The NIS contains data from over 7 million hospitalizations in the US per year, generalizable to the American population. The NIS was queried for the CDI-9 code for either a primary or secondary diagnosis of CD (008.45). Information for demographic data, length of stay (LOS), mortality, and hospital charges was evaluated.

Results. There were 1,256,783 total discharges from 2000–2014 with CD as the primary diagnosis and 4,204,338 total discharges during the same period with CD listed as any diagnosis. The number of hospitalizations with CD as a primary diagnosis increased from 31,782 in 2000 to 107,760 in 2014. The number of hospitalizations with CD listed as any diagnosis increased from 134,518 to 361,945. Mean LOS decreased from 6.8 to 5.8 days and mean charges per hospitalization increased from $35,898 during the same time period. Aggregate charges increased from $0.51 billion to $3.87 billion annually. Inpatient mortality of CD hospitalizations decreased from 4.03% in 2005 to 1.67% in 2014. Approximately 42% of those admitted for CD were male and 58% were female.

Conclusion. This study demonstrates that the number of hospitalizations for CD has increased by 339% from 2000 to 2014. Inpatient mortality of CD has decreased, likely from earlier recognition and treatment of CD. The direct cost of admissions with CD as primary diagnosis is nearly $4 billion per year. Our findings affirm that CD infection is an epidemic that remains a significant source of morbidity and mortality with substantial hospitalization and cost burden. This data can be used to support a return on investment for intervention strategies to prevent CD transmission and for new therapies.

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accounting for admission prevalence and diagnostic test type and compared with rates during a 24-month baseline period before implementation of the LTCF Initiative.

Results. During the 35-month analysis period, there were 145,421 admissions, 9,844,927 resident-days, and 1,480 CC-LTCF-onset CDI cases nationwide for a pooled CDI LTCF-onset rate of 1.50/10,000 resident-days. The use of nucleic acid amplification testing (NAAT) increased from 77.8% to 83.5% of facilities during the analysis period. CC-LTCF-onset CDI rates decreased 36% (P < .0001 for trend) (Figure 1).

Conclusion. As with acute care, LTCF-onset CDI case rates declined coincident with implementation of an initiative featuring a four-part bundle of interventions.

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1283. Impact of Clostridium difficile Infection on Patients’ Quality of Life: a French Hospital Prospective Study
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Background. Few data are available on the impact of episodes of Clostridium difficile infection (CDI) on quality of life. The Cdiff32, a new specific health-related quality of life questionnaire recently validated, allows such a measurement (Garey et al. J Clin Gastroenterol 2016 Sep;50(8):631–7).

Methods. An observational prospective study was performed in 7 French acute-care facilities in 2016. All consecutive patients presenting with a bacteriologically-confirmed CDI during a hospital stay, regardless of reason for hospitalization, were enrolled. Two instruments were presented to patients at 7±2 days after CDI diagnosis: the Cdiff32 and a generic questionnaire the EQ-5D-3L. The Cdiff32 comprises 32 self-administered questions about the impact of CDI in 3 broad domains (physical, mental and social). The physical domain differentiates general (6 questions) and specific physical complaints (8 questions). The mental domain comprises 14 questions about current and future anxiety. Four questions cover the impact on social relationships. Each item is scored from 0 (worst score) to 100 (best score) and they are aggregated by domain and globally. Clinical variables were collected to characterize the infection severity (ZAR score) and comorbidities. A regression analysis of the Cdiff32 scores with the EQ-5D-3L was performed.

Results. 80 patients were enrolled and 3 were excluded because of missing data. The median age was 71 years and 45% were males. The global Cdiff32 score was 50.4 (SD 17.1) with a large variability among patients (min 18.3, max 98.2). The highest impact of CDI was observed on the general physical complaints (41.6), as well as the level of current anxiety (41.6). The score relating to the social relationships was the highest (63.7). The severity of CDI (as defined by the ZAR score) and the global Cdiff32 score were correlated essentially through the physical sub-score (P = 0.0154). Patients with recurrences had a lower mental score compared with patients with an initial episode (P = 0.0582). The regression analysis of global Cdiff32 score and EQ-5D-3L utility score showed a positive relationship (R2 = 0.317).

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