Disclosures. **Rebekah W. Moehring, MD, MPH**, **UpToDate, Inc.** (Other Financial or Material Support, Author Royalties)

1414. Real-World Study of Healthcare Resource Use and Costs Associated with Inappropriate and Suboptimal Antibiotic Use Among Females with Uncomplicated Urinary Tract Infection in the United States

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Session: P-81. UTIs

Background. Urinary tract infections (UTIs) are the most common outpatient infection requiring medical care in the US; but, despite Infectious Diseases Society of America 2011 guidelines for treating uncomplicated UTI (uUTI), variation in prescribing practices still exists. Few studies have used real-world data (RWD) to evaluate uUTI-associated healthcare resource use (HRU) and costs. We examined HRU and direct costs associated with appropriate *and* optimal (AP&OP) and inappropriate *or* suboptimal (IA/SO) antibiotic (AB) prescribing in females with uUTI using US RWD.

Methods. This retrospective cohort study used RWD from IBM MarketScan (commercial/Medicare claims) to examine uUTI-related HRU and costs (inpatient, emergency room, outpatient, pharmacy) per index uUTI episode and during 1-year follow-up among females (age $\geq$ 12 years) diagnosed with uUTI from July 1, 2013–December 31, 2017 (index date). Patients had an oral AB prescription ± 5 days of the index date, and continuous health plan enrollment $\geq$ 6 months pre/1 year post-index date; those with complicated UTI were excluded. Patients were stratified by AB prescription as follows: AP&OP = guideline-compliant and correct duration; IA/SO = guideline non-compliant/incorrect duration or re-prescription/switch within 28 days.

Results. The study included 557,669 patients. In the commercial population (n=517,664, mean age 37.7 years), fewer patients were prescribed AP&OP (11.8%) than IA/SO (88.2%) ABs, a trend also seen in the Medicare population (n=40,005, mean age 74.5 years). In both populations, adjusted average numbers of uUTI-related ambulatory visits and pharmacy claims were lower for the AP&OP cohort than the IA/SO cohort during index episode and 1-year followup (p < 0.0001, Table 1). In the commercial population, total adjusted uUTI-related costs were $194 (AP&OP) versus $274 (IA/SO; p < 0.0001); in the Medicare population, total adjusted uUTI-related costs were $253 (AP&OP) versus $355 (IA/SO; p < 0.0001) (Table 2).

Table 1. uUTI-related HRU for commercial and Medicare populations calculated using the GLM model

Outcome variable[‡]	Commercial population*(n=517,664)			Medicare population[†](n=40,005)		
	AP&OP prescription[§](n=60,132)	IA/SO prescription[§](n=300,660)	p-value	AP&OP prescription[§](n=2119)	IA/SO prescription[§](n=10,595)	p-value
Index uUTI episode (per patient)						
Ambulatory visits, n (95% CI)	1.0 (1.0, 1.0)	1.1 (1.1, 1.1)	< 0.0001[¶]	0.9 (0.9, 1.0)	1.0 (1.0, 1.1)	< 0.0001[¶]
Pharmacy claims, n (95% CI)	1.0 (1.0, 1.0)	1.2 (1.2, 1.2)	< 0.0001[¶]	1.0 (1.0, 1.1)	1.2 (1.2, 1.2)	< 0.0001[¶]
Proportion of patients with ambulatory visits, % (95% CI)	90.6 (90.4, 90.8)	90.5 (90.4, 90.6)	0.3897	83.5 (81.8, 85.0)	84.2 (83.4, 84.8)	0.4317
Proportion of patients with pharmacy claims, % (95% CI)	98.8 (98.7, 98.9)	98.8 (98.7, 98.8)	0.3425	97.3 (96.5, 97.9)	97.8 (97.5, 98.1)	0.0923
1-year follow-up period (per patient)						
Ambulatory visits, n (95% CI)	1.3 (1.3, 1.3)	1.4 (1.4, 1.4)	< 0.0001[¶]	1.3 (1.3, 1.4)	1.6 (1.6, 1.6)	< 0.0001[¶]
Pharmacy claims, n (95% CI)	1.3 (1.3, 1.3)	1.5 (1.5, 1.5)	< 0.0001[¶]	1.4 (1.3, 1.4)	1.7 (1.7, 1.7)	< 0.0001[¶]
Proportion of patients with ambulatory visits, % (95% CI)	92.3 (92.1, 92.5)	92.0 (91.9, 92.1)	0.0313[¶]	86.2 (84.7, 87.6)	87.3 (86.6, 87.9)	0.1858
Proportion of patients with pharmacy claims, % (95% CI)	98.9 (98.9, 99.0)	99.0 (98.9, 99.0)	0.5565	97.7 (97.0, 98.2)	98.3 (98.1, 98.6)	0.0375[¶]

*Mean (SD) age 37.7 (14.3) years; [†]Mean (SD) age 74.5 (7.9) years; [‡]All values shown are adjusted averages; [§]The appropriateness of a prescription was defined as follows: AP, a guideline-compliant AB (first-line fosfomycin, nitrofurantoin, or TMP-SMX alone); OP, an AB prescribed for the correct duration (1 day for fosfomycin, 3 days for TMP-SMX, and 5 days for nitrofurantoin); IA, a guideline non-compliant AB (e.g., use of an AB that is not first-line treatment, or contemporaneous use of two first-line ABs); SO, where evidence of treatment failure exists (receipt of intravenous ABs/switch to a different oral AB within 28 days of index date, or primary UTI diagnosis within 28 days of initial diagnosis); [¶]Statistically significant difference (p < 0.05).

AB, antibiotic; AP&OP, appropriate and optimal; CI, confidence interval; GLM, generalized linear model; HRU, healthcare resource use; IA/SO, inappropriate or suboptimal; SD, standard deviation; TMP-SMX, trimethoprim-sulfamethoxazole; UTI, urinary tract infection; uUTI, uncomplicated urinary tract infection

Table 2. uUTI-related costs for commercial and Medicare populations calculated using the GLM model

Outcome variables[‡]	Commercial population*(N=517,664)			Medicare population[†](N=40,005)		
	AP&OP prescription[§](n=60,132)	IA/SO prescription[§](n=300,660)	p-value	AP&OP prescription[§](n=2119)	IA/SO prescription[§](n=10,595)	p-value
Index uUTI episode (per patient)						
Outpatient ambulatory costs, $ (95% CI)	132 (131, 133)	170 (169, 170)	< 0.0001[¶]	158 (150, 166)	186 (182, 190)	< 0.0001[¶]
Pharmacy costs, $ (95% CI)	11 (11, 11)	15 (15, 15)		13 (13, 14)	16 (16, 16)	
Total costs: inpatient + ER + ambulatory + pharmacy, $ (95% CI)	174 (172, 176)	257 (256, 259)		236 (222, 250)	315 (306, 323)	
Total costs: ≤ 99th %ile by cohort, $ (95% CI)	144 (143, 145)	209 (209, 210)		167 (158, 176)	218 (213, 224)	
1-year follow-up period (per patient)						
Outpatient ambulatory costs, $ (95% CI)	174 (173, 176)	221 (220, 222)	< 0.0001[¶]	223 (212, 236)	228 (281, 295)	< 0.0001[¶]
Pharmacy costs, $ (95% CI)	15 (14, 15)	19 (19, 19)		18 (17, 19)	23 (23, 24)	
Total costs: inpatient + ER + ambulatory + pharmacy, $ (95% CI)	232 (230, 234)	330 (328, 331)		372 (350, 396)	498 (484, 512)	
Total costs: ≤ 99th %ile by cohort, $ (95% CI)	194 (193, 196)	274 (272, 275)		253 (246, 260)	355 (346, 364)	

*Mean (SD) age 37.7 (14.3) years; [†]Mean (SD) age 74.5 (7.9) years; [‡]All values shown are adjusted averages; [§]The appropriateness of a prescription was defined as follows: AP, a guideline-compliant AB (first-line fosfomycin, nitrofurantoin, or TMP-SMX alone); OP, an AB prescribed for the correct duration (1 day for fosfomycin, 3 days for TMP-SMX, and 5 days for nitrofurantoin); IA, a guideline non-compliant AB (e.g., use of an AB that is not first-line treatment, or contemporaneous use of two first-line ABs); SO, where evidence of treatment failure exists (receipt of intravenous ABs/switch to a different oral AB within 28 days of index date, or primary UTI diagnosis within 28 days of initial diagnosis); [¶]Statistically significant difference (p < 0.05).

AB, antibiotic; AP&OP, appropriate and optimal; CI, confidence interval; ER, emergency room; GLM, generalized linear model; IA/SO, inappropriate or suboptimal; SD, standard deviation; TMP-SMX, trimethoprim-sulfamethoxazole; UTI, urinary tract infection; uUTI, uncomplicated urinary tract infection; %ile, percentile

Conclusion. Overall uUTI-related HRU and costs in the US were low during index episodes and follow-up. However, females with uUTI prescribed IA/SO ABs were more likely to incur higher HRU and costs than those prescribed AP&OP ABs, suggesting an unmet need for training to optimize uUTI prescribing per US guidelines.

Disclosures. **Madison T. Preib, MPH**, **STATinMED Research** (Employee, Former employee of STATinMED Research, which received funding from GlaxoSmithKline plc. to conduct this study) **Fanny S. Mitrani-Gold, MPH**, **GlaxoSmithKline plc.** (Employee, Shareholder) **Xiaoxi Sun, MA**, **STATinMED Research** (Employee, Employee of STATinMED Research, which received funding from GlaxoSmithKline plc. to conduct this study) **Christopher Adams, MPH**, **STATinMED Research** (Employee, Employee of STATinMED Research, which received funding from GlaxoSmithKline plc. to conduct this study) **Ashish V. Joshi, PhD**, **GlaxoSmithKline plc.** (Employee, Shareholder)

1415. Allergies to Antimicrobial Agents Among US Females with Uncomplicated Urinary Tract Infection

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Session: P-81. UTIs

Background. Uncomplicated urinary tract infections (uUTI) are generally treated empirically with antibiotics. However, antibiotic (AB) allergies limit the available oral treatment options for some patients. We assessed the proportion of self-reported AB allergies among US females with uUTI.

Methods. We performed a cross-sectional survey of US females $\geq$ 18 years of age with a self-reported urinary tract infection (UTI) in the 60 days prior to participation and a prescription of oral AB. Participants were further screened for evidence of a complicated urinary tract infection and, after exclusions, participants with a uUTI completed an online questionnaire about their most recent episode. Participants were from the Northeast (20%), Midwest (44%), South (20%), and West (16%) US. Descriptive self-reported allergy data were stratified into subgroups by whether the participant had recurrent UTI (defined as $\geq$ 2 uUTIs in the past 6 months or $\geq$ 3 uUTIs in past 12 months including index UTI), the number of different ABs given for the index episode (1, 2, $\geq$ 3), and whether the treatment was clinically appropriate according to Infectious Diseases Society of America uUTI guidelines.

Results. Overall, 375 female participants completed the questionnaire. The most commonly prescribed ABs for participants' most recent uUTI were trimethoprim-sulfamethoxazole (TMP-SMX; 38.7%), ciprofloxacin (22.7%), and nitrofurantoin (18.9%) (Table 1). Most participants received only 1 AB for their uUTI (62.7%) and the majority were classified as having a non-recurrent uUTI (56.5%). No AB allergies were reported for most participants (69.3%); overall, 24.0% reported 1 AB allergy and 6.7% reported $\geq$ 2. A higher proportion of participants reported $\geq$ 2 allergies in the recurrent uUTI, $\geq$ 3 AB, and multiple AB subgroups (Table 2). The most common allergy was to TMP-SMX (15.7%), followed by amoxicillin-clavulanate (8.3%) and ciprofloxacin (5.3%) (Table 2). Similar allergy trends were seen across subgroups, except higher rates of ciprofloxacin allergy were seen in participants given multiple ABs (Table 2).

Table 1. Antibiotics used to treat most recent uUTI

Antibiotic used to treat most recent uUTI (N=375)	n (%)
Trimethoprim-sulfamethoxazole	145 (38.7)
Ciprofloxacin	85 (22.7)
Nitrofurantoin	71 (18.9)
Cephalexin	56 (14.9)
Amoxicillin-clavulanate	35 (9.3)
Levofloxacin	11 (2.9)
Ofloxacin	10 (2.7)
Cefdinir	5 (1.3)
Fosfomycin	2 (0.5)
Cefaclor	0
Cefpodoxime-proxetil	0

uUTI, uncomplicated urinary tract infection.

Table 2. Frequency of antibiotic allergies across cohort subgroups

	Total(N=375)	Recurrent uUTI		Number of AB for recent uUTI			Appropriateness of treatment		
		Yes(n=163, 43.5%)	No(n=212, 56.5%)	1 AB(n=235, 62.7%)	2 AB(n=88, 23.5%)	≥ 3 AB(n=52, 13.9%)	1 AB/1st line*(n=123, 32.8%)	1 AB/2nd line[†](n=112, 29.9%)	Multiple AB[‡](n=140, 37.3%)
	Antibiotic allergies, n (%)								
0	260 (69.3)	116 (71.2)	144 (67.9)	164 (69.8)	62 (70.5)	34 (65.4)	91 (74.0)	73 (65.2)	96 (68.6)
1	90 (24.0)	33 (20.2)	57 (26.9)	61 (26.0)	18 (20.5)	11 (21.2)	28 (22.8)	33 (29.5)	29 (20.7)
≥ 2	25 (6.7)	14 (8.6)	11 (5.2)	10 (4.3)	8 (9.1)	7 (13.5)	4 (3.3)	6 (5.4)	15 (10.7)
Trimethoprim-sulfamethoxazole	59 (15.7)	28 (17.2)	31 (14.6)	33 (14.0)	18 (20.5)	8 (15.4)	14 (11.4)	19 (17.0)	26 (18.6)
Amoxicillin-clavulanate	31 (8.3)	16 (9.8)	15 (7.1)	21 (8.9)	4 (4.5)	6 (11.5)	6 (4.9)	15 (13.4)	10 (7.1)
Ciprofloxacin	20 (5.3)	10 (6.1)	10 (4.7)	9 (3.8)	5 (5.7)	6 (11.5)	6 (4.9)	3 (2.7)	11 (7.9)
Cephalexin	14 (3.7)	6 (3.7)	8 (3.8)	9 (3.8)	2 (2.3)	3 (5.8)	5 (4.1)	4 (3.6)	5 (3.6)
Nitrofurantoin	7 (1.9)	1 (0.6)	6 (2.8)	6 (2.6)	0	1 (1.9)	2 (1.6)	4 (3.6)	1 (0.7)
Levofloxacin	5 (1.3)	3 (1.8)	2 (0.9)	2 (0.9)	1 (1.1)	2 (3.8)	0	2 (1.8)	3 (2.1)
Cefaclor	4 (1.1)	1 (0.6)	3 (1.4)	4 (1.7)	0	0	3 (2.4)	1 (0.9)	0
Ofloxacin	4 (1.1)	0	4 (1.9)	2 (0.9)	2 (2.3)	0	2 (1.6)	0	2 (1.4)
Cefdinir	4 (1.1)	3 (1.8)	0	1 (0.4)	2 (2.3)	0	0	1 (0.9)	2 (1.4)
Cefpodoxime-proxetil	2 (0.5)	0	2 (0.9)	1 (0.4)	1 (1.1)	0	0	1 (0.9)	1 (0.7)
Fosfomycin	0	0	0	0	0	0	0	0	0

*Defined as only one first-line oral AB used to treat last uUTI; [†]Defined as only one second-line oral AB used to treat last uUTI; [‡]Defined as two or more different oral AB (any line) used to treat last uUTI.

AB, antibiotic; uUTI, uncomplicated urinary tract infection.

Conclusion. AB allergies were relatively frequent in this uUTI cohort and the most common allergy was to TMP-SMX, which was the most prescribed AB. Allergies to ABs reduce the available treatment options for uUTI in some patients.

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1416. Medicare Spending on Urinary Tract Infections: A Retrospective Database Analysis

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Session: P-81. UTIs

Background. Medical visits for UTIs represent 1%-6% of all healthcare visits (~7 million visits) and are estimated to cost the United States (US) healthcare system at least $1.6 billion annually. UTIs are associated with significant morbidity; particularly among the elderly, where UTIs are most prevalent. Little is known about the specific costs to Medicare of UTI; here, we seek to examine overall Medicare spending on UTI.

Methods. We conducted a retrospective multicenter cohort study of the Medicare fee-for-service (FFS) data. Patients were included for analysis if the following criteria were met: (1) enrolled in Medicare FFS from January 1, 2016 through December 31, 2019, (2) not enrolled in Medicare Advantage during that time period, (3) did not have any UTI diagnoses in 2016, and (4) enrolled in Medicare Part D. Individuals were categorized as having uncomplicated UTI (uUTI), complicated UTI (cUTI), or those who first had a uUTI that progressed to a cUTI (uUTI to cUTI). Medicare spending in the 12 months post-diagnosis was calculated, and patients were stratified by home- or institutionally-based (eg, nursing home, long-term care facility, etc.).

Results. 2,330,123 patients were included for analysis; 92% were home-based, 8% were institutionally-based. Mean Charlson Comorbidity Index (CCI) across all patients was 2.16. In the 12 months after initial diagnosis, average Medicare spend was $33,984, $9,941 of which was UTI-related. Annual UTI-related costs were approximated $9,000 for home-based vs. $21,444 for institutionally-based patients. Mean drug spend per patient on antibiotics was $872. Broadly, uUTI patients were least expensive, followed by cUTI patients, with uUTI to cUTI patients being most expensive. Higher costs for were observed for institutionally-based patients, largely due to more frequent acute hospitalizations and more Part A-paid skilled nursing stays.

Conclusion. UTI-related spending represents approximately one-third of total annual Medicare spend for patients diagnosed with a UTI. Given average Medicare spending of approximately $12,000 per person in 2019, UTI is associated with substantially increased per patient cost and represents a significant source of spending for Medicare.

Disclosures. **Kate Sulham, MPH, Spero Therapeutics** (Consultant) **Eric Hammelman, MBA, AbbVie Pharmaceuticals** (Consultant)**Edwards Lifesciences** (Consultant)**Genentech** (Consultant)**Spero Therapeutics** (Consultant)**Vertex Pharmaceuticals** (Consultant)

1417. Fosfomycin Use in the Treatment of Complicated Urinary Tract Infections at a Veterans Affairs Medical Center

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Session: P-81. UTIs

Background. The prevalence of multidrug resistant gram-negative urinary tract infections (UTIs) is increasing, often requiring intravenous antimicrobial therapy. Oral fosfomycin is a recommended alternative agent for the treatment of cystitis caused by extended spectrum beta-lactamase (ESBL)-producing *Escherichia coli* (E. coli). The primary objective of this study is to evaluate the efficacy of fosfomycin in the treatment of UTIs at the Veterans Affairs Long Beach Healthcare System. The secondary objective is to assess the incidence of adverse drug reactions associated with fosfomycin.

Methods. This is a retrospective, single-center, cohort study. Patients who received fosfomycin between June 1st, 2015 – June 30th, 2020 were included. Data collection was completed by chart review through the Computerized Patient Record System (CPRS). Descriptive analysis was used to evaluate data. Treatment outcomes were analyzed using a composite of clinical and microbiological cure. Clinical cure was defined as resolution of UTI symptoms. Microbiological cure was defined as urine sterilization within 1 month after completing treatment course with fosfomycin.

Results. A total of 62 unique patients were evaluated in this study. The mean age was 71.9 years. 56 patients (90.3%) were male, 31 patients (50.0%) had an indwelling catheter present at the time of treatment, and 48 patients (77.4%) had the presence of genitourinary tract pathology that may increase the risk of developing UTIs. Majority of patients (50%) had a urine culture result positive for *E. coli* prior to treatment, of which 43.5% were ESBL-producing. 60 patients (96.8%) received more than 1 dose of Fosfomycin. Out of 29 patients who were eligible to be evaluated for clinical outcomes, 20 patients (68.9%) met a positive composite outcome of either microbiological cure, clinical cure, or both. 4 patients (6.5%) experienced an adverse drug reaction of diarrhea that was self-limited.

Conclusion. Fosfomycin is an effective and well-tolerated antimicrobial agent that may be considered for treatment of complicated UTIs without evidence of pyelonephritis or bacteremia caused by multi-drug resistant organisms in the veteran population.

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1418. Single Center Treatment Patterns for Asymptomatic Bacteriuria and UTIs in Kidney Transplant Recipients: Are We Still Overtreating?

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Session: P-81. UTIs

Background. In February 2019, the American Society of Transplantation (AST) published guidelines on the management of asymptomatic bacteriuria (AB) and urinary tract infections (UTIs) in kidney transplant (KT) recipients. These recommendations include avoiding treatment of AB > 2 months post-transplant and outline the duration of treatment (DT) for uncomplicated and complicated UTIs. We reviewed management of these syndromes and guideline concordance at our institution.

Methods. We conducted a single-center, retrospective cohort study of KT recipients age > 18 years who underwent transplantation between June 2016 - June 2020. Patients were obtained through query of our electronic medical record for documented UTI syndromes and included if a diagnosis was confirmed between March 2019 - December 2020 upon chart review. Definitions of AB, complicated UTI, and uncomplicated UTI were based on AST definitions. Patients with AB < 2 months post-transplant were excluded. Outcomes included treatment of AB, DT, 30-day hospital admission and re-admission, and 30-day mortality. Bivariate analysis was conducted using chi square and t test.

Results. Seventy-four patients (mean age 55.4 years, 62.0% female) were included. Twenty-one patients had AB, 90% of whom received antibiotics. Distribution of diagnoses and median DT among those treated with antibiotics is outlined in Table 1.

Overall DT was similar in patients whose care included infectious disease (ID) input and those who did not (10.0 vs. 10.0 days, p=0.12), although ID involvement was more common in complicated UTIs. There was no difference in 30-day admission rates for those receiving < 7 days vs. > 7 days of antibiotics (p=0.53) (Table 2) including those with complicated UTIs (5/15 in < 7 days (33%) vs. 4/18 in > 7 days (22%) p=0.49). There were no deaths within 30 days of diagnoses.

Table 1	UTI Subgroup Distribution and Duration of Antibiotics for Treated Patients					
Diagnosis	Total	AB	Uncomplicated UTI	Complicated UTI	Complicated UTI - Other[a]	No UTI[b]
n (%)	72	19 (26)	6 (8)	33 (46)	9 (13)	5 (7)
Antibiotic Duration median days (Interquartile range)	10 (7-14)	10 (7-12)	14 (10-14)	7 (7-14)	27 (10-42)	7 (7-10)
Treatment Setting						
Outpatient n (%)	30	15 (50)	5 (17)	6 (20)	0 (0)	4 (13)
Inpatient n (%)	42	4 (10)	1 (3)	27 (64)	9 (21)	1 (2)
ID Consultation						
No ID Consult n (%)	34	16 (47)	6 (18)	7 (20)	0 (0)	5 (15)
ID Consult n (%)	38	3 (8)	0 (0)	26 (68)	9 (24)	0 (0)

[a]Includes renal abscess, hematoma, epididymidoorchitis, or concurrent non-UTI infection present (i.e. surgical site infection)
[b]Patients who were given antimicrobials but did not have evidence of AB or UTI according to guideline criteria or an alternative explanation for antibiotic use

Table 2	30-day Hospital Admissions			
	Total n	Not admitted within 30 days n (%)	Admitted within 30 days n (%)	p value
n (%)	72	58 (81)	14 (19)	
Antibiotic Duration				
≤ 7 days	31	26 (84)	5 (16)	0.53
> 7 days	41	32 (78)	9 (22)	
Uropathogen Sensitivity				
Non-MDRO[c]	62	50 (81)	12 (19)	0.96
MDRO	10	8 (80)	2 (20)	

[c]Multi-drug resistant organism

Conclusion. Despite guidelines, treatment of AB is common and uncomplicated UTIs often receive prolonged courses of antibiotics. There was no increased risk of admission or mortality with shorter DT, though these results should be interpreted cautiously given the small sample size. Greater stewardship efforts are needed in this high-risk population.

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1419. High Prevalence of Fluoroquinolone-Resistant Urinary Tract Infection Among US Emergency Department Patients Diagnosed with UTI, 2018-2020

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