physiological variables such as the patient’s temperature, blood pressure and pulse at diagnosis of CDAD were recorded as were any haematological and biochemical investigations taken within 24 h of diagnosis.

**Results** Hospital admissions between 14 and 30 days (p=0.031), increasing co-morbidities (p=0.05), systolic blood pressure <100 mm Hg (p=0.048) and heart rate greater than 100 beats per minute (p=0.048) were significantly associated with increased 30-day mortality. There was a clear trend of increased mortality for increasing length of stay (LOS) on the current admission before development of diarrhoea (if LOS greater than 7 days before onset, p=0.07), temperature <35°C (p=0.07), recent discharge from hospital within 30 days (p=0.106) and to a lesser degree, low albumin (<30 g/l p=0.221) at the time of diagnosis, age >85 years (p=0.947) and current PPI use (p=0.224). From the data, a scoring system was derived whereby 1 point was given to the non-statistically significant trends and 2 points to the statistically significant trends. If there were 1 to 5 co-morbidities, this was scored as 1 and greater than 5 co-morbidities scored as 2. There was a maximum score of 14. On applying this retrospectively to the existing database, 39 patients were identified where all the parameters in the scoring system were available. Of these, a score of 4 or less was associated with low risk of 30-day mortality (0% mortality in 15 patients) and a score of 5 or more to be associated with a high risk of 30-day mortality (72.7% mortality in 11 patients).

**Conclusion** A simple scoring system holds promise for defining those patients at greatest risk of 30-day mortality from CDAD in our population. However a note of caution should be exercised. Applying a scoring system retrospectively to a dataset from which information has been used to derive the score does not validate it and a prospective study is planned to validate the York scoring system.

**Competing interests** None declared.