TREATMENT OF RECURRENT *Clostridioides difficile* INFECTION (CDI) in Adults

NHS Tayside

After a first episode, recurrent disease occurs in about 20% of patients. After a first recurrence, the risk of another infection increases to 45-60%.

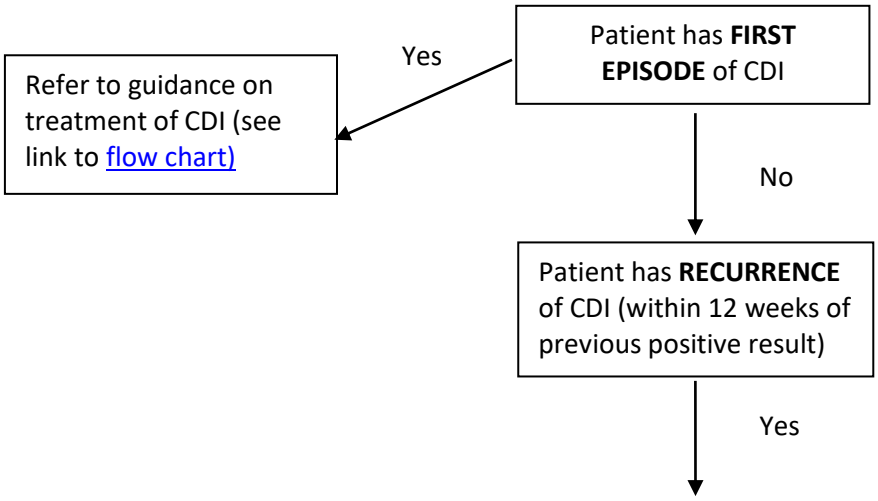
Recurrent disease is caused either by re-infection from a contaminated environment or poor hand hygiene, or relapse from germinating spores in the gut. Relapses tend to occur within the first 2 weeks after treatment cessation.

Recurrent infection is defined as CDI that re-occurs within 12 weeks of previous positive result.

The following recommendations apply to all patients with CDI:

- Suspect CDI infection in patients with diarrhoea who are **on antibiotics, or who have had antibiotics in preceding 12 weeks.**
- Send stool sample to microbiology for **CDI testing** for suspected infection or recurrence. Inform Infection Prevention and Control Team and adopt contact precautions. **Isolate patient if possible and wash hands with soap and water.**
- **Discontinue precipitating antibiotics** if possible. If antibiotics are necessary, discuss choice of antibiotic with microbiology or ID. Concomitant antibiotics are associated with an increased risk of recurrence of symptoms.
- Discontinue all antidiarrhoeal and laxative medications.
- Consider temporarily discontinuing or reducing dose of proton pump inhibitors/H2 receptor antagonists.
    - Clinical situations where PPIs should be continued include:
      Barretts oesophagus, severe GORD with previous ulceration or structuring, Zollinger Ellison syndrome (rare), previous peptic ulceration on NSAIDs/aspirin/antiplatelets, rheumatology patients on NSAIDs requiring gastric protection

- **It may take 3-5 days for clinical response after initiation of treatment.**
- **After clinical response, it may take weeks for stool consistency and frequency to become entirely normal.**
- **Test of cure should NOT be performed.**



RECURRENCE	TREATMENT FOR NON SEVERE /SEVERE CDI Document indication and duration on EKORA and HEPMA
FIRST RECURRENCE (SECOND EPISODE)	**Treat with fidaxomicin** **Contact ID or Microbiology for approval to prescribe:** Fidaxomicin 200mg twice daily for 10 days* **(Exception –** treatment failure due to incomplete treatment course (treat as per 1st line treatment with Vancomycin 125mg QDS for 10 days) Refer to CDI treatment flow chart for details of monitoring patient, when to refer to ID or Surgery and options if oral route not available

RECURRENCE	TREATMENT FOR NON SEVERE /SEVERE CDI Document indication and duration on EKORA and HEPMA
SECOND RECURRENCE (THIRD EPISODE)	Second recurrence of CDI: Discuss with infection specialist and consider: Faecal Microbiota Transplant (FMT) - Supplied through University of Birmingham – **contact ID to arrange** If FMT is not available then consider tapering Vancomycin regime as below: Vancomycin Tapering Regime (6 weeks total) 125mg qds for 1 week 125mg tds for 1 week 125mg bd for 1 week 125mg od for 1 week 125mg alternate days for 1 week 125mg every 3rd day for 1 week Refer to CDI treatment flow chart for details of monitoring patient.
FURTHER RECURRENCES	Patients could be started on Vancomycin 125mg qds for 10 days but all patients should be referred to ID or Microbiology for further options as below: **ID or Microbiology advice is essential for all options below:** • Fidaxomicin 200mg bd for 10 days • Consider IgG therapy (400mg/kg stat dose – link to guidance) • Conservative management +/- loperamide used under supervision, only if there is no evidence of severe CDI or abdominal symptoms • Vancomycin then rifaxamin 'chaser' 400mg bd for 14 days (off label use) • Nitazoxinide 500mg bd 7-10 days (unlicensed) Refer to CDI treatment flow chart for details of monitoring patient, when to refer to ID or Surgery.

*GPs can prescribe fidaxomicin under the specialist direction of Infectious Diseases or Medical Microbiology only. Community Pharmacists will not routinely stock this product so it would be prudent to communicate, at the earliest opportunity, with the patient's regular pharmacy to expect a prescription.

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References: European Society of Clinical Microbiology and Infectious Diseases: 2021
IDSA Guidance 2021 C.Diff
NICE Guidance 2021
SAPG Feb 2022