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 8 weeks of previous positive result.

The following recommendations apply to all patients with CDI:

- **Suspect** *C. difficile* infection in patients with diarrhoea who are on antibiotics, or who have had antibiotics in preceding 12 weeks.
- Send stool sample to microbiology for *C. difficile* testing for suspected infection or recurrence. Inform Infection Control Team and adopt enteric 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 anti diarrhoeal 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.**

<table>
<thead>
<tr>
<th>RECURRENCE</th>
<th>TREATMENT FOR NON SEVERE CDI</th>
<th>TREATMENT FOR SEVERE CDI</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRST RECURRENCE (SECOND EPISODE)</td>
<td>Contact ID or Microbiology for approval to prescribe: fidaxomicin 200mg twice daily for 10 days*</td>
<td>Contact ID or Microbiology for approval to prescribe: fidaxomicin 200mg twice daily for 10 days</td>
</tr>
<tr>
<td></td>
<td>Refer to CDI treatment <a href="#">flow chart</a> for details of monitoring patient.</td>
<td>Refer to CDI treatment <a href="#">flow chart</a> for details of monitoring patient, when to refer to ID or Surgery.</td>
</tr>
</tbody>
</table>

**UNDETAKE SEVERITY ASSESSMENT AND RECORD IN MEDICAL NOTES**

- One or more of the following severity markers:
  - Temperature > 38.5°C
  - Ileus, colonic dilatation >6cm on AXR/CT, toxic megacolon and/or pseudomembranous colitis
  - WBC >15 cells x 10⁹L
  - Acute rising serum creatinine >1.5 x baseline
  - Has persisting CDI where the patient has remained symptomatic and toxin positive despite 2 courses of appropriate therapy

---

Patient has **FIRST EPISODE** of CDI

No

Patient has **RECURRENCE** of CDI (within 8 weeks of previous positive result)

Yes

Refer to guidance on treatment of CDI (see link to [flow chart](#))

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**CONTACT ID OR MICROBIOLOGY FOR APPROVAL TO PRESCRIBE:**

- fidaxomicin 200mg twice daily for 10 days

---

**CONTACT ID OR MICROBIOLOGY FOR APPROVAL TO PRESCRIBE:***

- fidaxomicin 200mg twice daily for 10 days

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**RECORD INDICATION AND DURATION ON MEDICINE CHART AND SCORE OFF ADMINISTRATION BOXES NOT REQUIRED**
<table>
<thead>
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<th>Recurrence</th>
<th>Treatment for Non Severe CDI</th>
<th>Treatment for Severe CDI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Second Recurrence (Third Episode)</strong></td>
<td>If the patient has not previously had a course of fidaxomicin then: Contact ID or Microbiology for approval to prescribe: Fidaxomicin 200mg twice daily for 10 days* If patient has had a course of fidaxomicin previously then prescribe: 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 <a href="#">flow chart</a> for details of monitoring patient. Also consider referral for faecal transplant</td>
<td>If the patient has not previously had a course of fidaxomicin then: Contact ID or Microbiology for approval to prescribe: Fidaxomicin 200mg twice daily for 10 days* If patient has had a course of fidaxomicin previously then prescribe: Vancomycin Tapering Regime (6 weeks total) 125mg qds for 10 days 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 <a href="#">flow chart</a> for details of monitoring patient, when to refer to ID or Surgery and options if oral route not available. Also consider referral for faecal transplant</td>
</tr>
<tr>
<td><strong>Third Recurrence (Fourth Episode)</strong></td>
<td>Faecal transplant is recommended (including vancomycin 500mg qds for 4 days). If faecal transplant is not possible, treat as per second recurrence.</td>
<td>Vancomycin 125mg qds for 10 days Refer to CDI treatment <a href="#">flow chart</a> for details of monitoring patient, when to refer to ID or Surgery and options if oral route not available.</td>
</tr>
</tbody>
</table>
| **Further Recurrence** | 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 rifaximin ‘chaser’ 400mg bd for 14 days (off label use)  
- Nitazoxinide 500mg bd 7-10 days (unlicensed) | Vancomycin 125mg qds for 10 days Refer to CDI treatment [flow chart](#) for details of monitoring patient, when to refer to ID or Surgery. Discuss with ID or Microbiology other options |

*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. The cost of a course of fidaxomicin is in the region of £1000.

References:  
HPS 2017 Guidance  
SAPG 2014 PPI Guidance

Note: All cases defined as severe CDI, including those where it was a cause or contributory factor in death are required to be reviewed using the HPS tool and any actions identified as a result of review are shared within Clinical Governance and Performance Review and the wider organisation as appropriate. Please liaise with Infection Control Team.