Guidance for Proven or Suspected *Clostridioides difficile* Infection (CDI) in Adults

NHS Tayside

Constipation with overflow diarrhoea (make sure PR done), laxatives and other common causes of diarrhoea have been excluded

Pregnancy:
Vancomycin can be used at standard dosing.
Assess patient using the same severity assessment as non-pregnant patients.

Does patient have risk factors for CDI?
- History of recent (<3m) or current antibiotic use
- Prolonged recent hospital stay
- Use of PPI/H_2 antagonists
- Increasing age especially > 65y
- Surgical procedure (in particular bowel procedures)
- Immunosuppression

YES

Review PP/H_2RAs*
Stop laxatives
Stop anti-microbial treatment if possible (continuing antimicrobials can ↑risk of recurrence)
Stop anti-motility agents

*** Clinical situations where PPIs should be continued include:**
Barretts oesophagus, severe GORD with previous ulceration / structuring, Zollinger Ellison syndrome (rare), previous peptic ulceration on NSAIDs/aspirin/antiplatelets, rheumatology patients on NSAIDs requiring gastric protection

Send stool sample for CDI testing (Syndromic PCR: gastroenteritis)
Ensure stool chart/fluid balance chart in situ

Inform Infection Prevention and Control Team
- Isolate patient in single room
- Designated toilet or commode
- Hand hygiene with soap and water.
- Environmental cleaning
- Adopt contact precautions

Indeterminate Result *(PCR positive and toxin negative)*

If patient symptomatic, then consider other medication and causes of diarrhoea. If high suspicion of CDI send repeat stool sample for testing and start treatment without confirmation test.

Test +ve *(PCR and toxin positive)*

Test -ve *(PCR negative)*

Discontinue CDI guidance or if suspicion high seek ID referral

Is this a recurrence?
(within 12 weeks of previous positive result)

Yes → See Guidance on Treatment of Recurrent CDI

No

1st Line Treatment for first clinical episode or recurrence out with 12 weeks:
- Treat with **oral vancomycin 125mg qds for 10 days.** Document duration on HEPMA
- If oral route not available give via NG tube. For guidance on how to give rectal or NG vancomycin click here
- Rehydrate patient and consider referral to hospital or healthcare facility if patient at home

2nd Line treatment *(for patients who fail to improve after 7 days or who deteriorate)*
- Discuss with ID – treatment will depend on severity of patient.
- Fidaxomicin 200mg twice daily for 10 days
- **OR**
- Oral vancomycin 500mg qds **+/-** IV Metronidazole 500mg tds for 10 days

Ensure documentation of DAILY clinical assessment of patient in medical notes/EKORA:

- Observe and record bowel movements, other symptoms (e.g. WBC, hypotension, fever) nutrition and fluid balance and for signs of increasing severity.
- Where patient shows signs of clinical improvement, continue with vancomycin. No need for test of cure.
- **ID referral:** required for patients who are not responding to treatment or deteriorating on treatment

- **Surgical consultation:** required for patients with life threatening disease i.e. any ONE of the following: admission to ICU for CDI, hypotension with or without required use of vasopressors; ileus or significant abdominal distension, mental status changes, WBC ≥35 or <2; serum lactate >2.2mmol/l; end organ failure
  If ileus is detected or NG route not available treat with IV metronidazole 500mg tds plus NG/rectal vancomycin 500mg qds until ileus is resolved. (If ileus contact microbiology for advise on testing).

Contact Details:
- Infection prevention and control team via switchboard or Tay.infectioncontrol@nhs.scot
- Public health via NWH switchboard if Care Home
- On call duty microbiologist: 4039 Ninewells or through switchboard
- On call ID: Tay.id@nhs.scot or bleep 5075

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References: HPS 2017 Guidance IDSA Guidance C.Diff 2021 NICE Guidance 2021 SAPG Guidance 2022 (updated 2024) European Society of clinical Microbiology and Infectious Diseases 2021