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

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

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

YES

Send stool for CDI testing
Ensure stool chart/fluid balance chart in situ

Inform Infection Prevention and Control Team

Isolate patient in single room
Designated toilet or commode

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

Hand hygiene with soap and water
Wear gloves and disposable apron

Test -ve

Indeterminate Result

Test +ve

Discontinue CDI guidance or if index of suspicion high seek ID referral

If clinical suspicion of CDI do not wait for confirmatory test

UNDERTAKE 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 10^9L
- 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

*** 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

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 indication and duration on medicine chart
- 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 worsen on oral treatment*)

- 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 assessment of patient in medical notes:

- 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.
- **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 vancomycin 500mg qds (via NG or intracolonic) until ileus is resolved.

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
- On call ID: Tay.id@nhs.scot or bleep 5075

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References: HPS 2017 Guidance IDSA Guidance C.Diff 2017 NICE Guidance 2021

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 IPC Team.