COMMUNITY MANAGEMENT OF CLOSTRIDIUM DIFFICILE INFECTION PATHWAY

(compliments Antibiotic Prescribing in the Community Guidelines)

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- Exclude alternative causes of diarrhoea*
- Send stool sample for *C.difficile* toxin test*

Suspected* or confirmed CDI

Patients with **no history of CDI or an episode more than 30 days ago** should enter the pathway here

- Discontinue (if possible) non CDI treatment antimicrobials
- Discontinue laxatives and anti-motility agents for duration of diarrhoea
- Consider stopping symptom masking opioids for duration of diarrhoea
- Switch PPI's to lower risk H_2RA drugs or alginates
- **Assess markers of disease severity**[1]

Available at http://tinyurl.com/njgnknt

Mild Typically <3 stools (T5-7) daily, no or mild abdominal discomfort
No raised WCC
Moderate Typically 3-5 stools (T 5-7) daily, moderate abdominal discomfort / cramping
Raised WCC but <15x10^9/L

Severe Temperature >38.5°C, severe abdominal discomfort / cramping / distension, No. of stools less reliable indicator of severity
WCC >15x10^9/L, or acute rising serum creatinine (i.e. >50% increase above baseline), or evidence of severe colitis

Mild/Moderate CDI

Treat in the community

Oral metronidazole
400mg TDS for 10-14 days
with regular assessment^

Re-assessment at 5 days
(70% of patients respond to metronidazole within 5 days, 92% in 14 days)

Clinical improvement or stable

Complete treatment course

No diarrhoea for 48 hours

CLINICAL CURE#

Continued diarrhoea

Continued diarrhoea with no response to treatment or clinical

Severe CDI

e.g. evidence of obstruction / ileus, severe colitis, AKI

Admit to hospital

Oral vancomycin
125mg QDS for 10-14 days
with daily assessment^

Patients **with a previous episode within 30 days** that was treated with **metronidazole** should enter the pathway here

Clinical improvement or no change

Deterioration

Admit to hospital

Complete treatment course

No diarrhoea for 48 hours

CLINICAL CURE#

Continued diarrhoea
Exclude alternative causes of diarrhoea$

$ consider post infective irritable bowel syndrome if diarrhoea continues despite 20 days treatment in a clinically stable patient. Discuss anti-motility agent with a CCM

Oral vancomycin
125-500*mg QDS for 10-14 days[1] with daily assessment^.
(*use higher dose vancomycin if no response to 125mg QDS). Tapering course of vancomycin (after initial treatment) **Week 1:** 125mg QDS **Week 2:** 125mg TDS **Week 3:** 125mg **BD Week 4:** 125mg OD **Week 5:** 125mg alternate days **Week 6:** 125mg every third day[1]

Patients **with a previous episode within 30 days** that was treated with **vancomycin** should enter the pathway here

No diarrhoea for 48 hours

CLINICAL CURE#

Continued diarrhoea* or relapse
Exclude alternative causes of diarrhoea

Refer for Faecal Microbiota Transplant[2]
using local guidelines, symptom management with PO vancomycin 125mg QDS

IN SPECIFIC CASES WHERE FMT CONTRAINDICATED CONSIDER
Oral fidaxomicin 200mg BD for 10 days[3] following discussion with a Consultant Clinical Microbiologist (CCM)~

~ Criteria for the use of fidaxomicin

- Recommendation by a CCM
- Use in moderate/ severe cases following treatment failure with vancomycin
- Maximum one treatment course
- Patients should fulfil:
  - Age >65 yeas
  - Multiple co-morbidities - Horn's Index SEVERE (major complications or multiple conditions requiring treatment) or FULMINANT (catastrophic life threatening illness)
  - Concomitant antimicrobial use[1,4,5]

#Future prevention[1]

- Do not re-test the patient for clearance
- Use any future antimicrobial with caution
- Consider back-up antimicrobial prescriptions as appropriate
- Avoid high risk antimicrobials (clindamycin, ciprofloxacin, co-amoxiclav, cephalosporin's)
- Use H_2RA or alginates in place of PPI's

^Assessment checks[1]

- TPR & BP
- Hydration status
- Abdominal examination, (abdominal pain, discomfort and distension)
- Stool output
- Nutritional intake
- Weekly WCC, FBC, CRP, U&E's, Albumin

developed by NHS West Hampshire Clinical Commissioning Group

Abbreviations

BD – Twice daily
BP – Blood Pressure
CDI – Clostridium difficile Infection
CCM – Consultant Medical Microbiologist
CRP – C-Reactive Protein
FBC – Full Blood Count
FMT – Faecal Microbiota Transplant
H_2RA – H2 Receptor Antagonist
QD – Once daily
PPI – Proton Pump Inhibitor
QDS – Four times daily
TDS – Three times daily
TPR Temperature, Pulse, Respiration
U&E – Urea and Creatinine
WCC – White Cell Count (total)

References

1. Public Health England. Updated guidance on the management and treatment of Clostridium difficile infection, May 2013
2. National Institute for Health and Care Excellence IPG485 Faecal microbiota transplant for recurrent Clostridium difficile infection. March 2014
3. National Institute for Health and Care Excellence ESNM1 Clostridium difficile infection: fidaxomicin July 2012,
4. Hu MY, Katchar K, Kyne L, et al. Prospective derivation and validation of a clinical prediction rule for recurrent Clostridium difficile infection. Gastroenterology 2009; 136: 1206-14.
5. Arora V, Kachroo S, Ghantoji SS et al. High Horn's index score predicts poor outcomes in patients with Clostridium difficile infection Journal of Hospital Infection 79 (2011) 23e26