GUIDANCE AT A GLANCE - CLOSTRIDIUM DIFFICILE

These guidelines support the control and prevention of *C. difficile* in community and primary care settings.
Key Ref: PHE (2013) Updated guidance on the management and treatment of *Clostridium difficile* infection

### Early diagnosis prevents complications and saves lives

- Prudent prescribing of antibiotics may prevent infection
- Communication of infection risk helps prevent cross infection
- Alcohol hand rub is **ineffective** at killing *C. difficile* spores.
- Review Risk factors for infection = over 65’s, recent hospitalisation, recent antibiotics, GI procedures and gastric ulcer medications

### Key Points

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### Microbiologist for prescribing an
d treatment advice

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Thanks to Calderdale IPC team for allowing adaptation of this guidance.
Infection Prevention and Control Team for resources and advice

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Treatment Algorithm for CDI

Diarrhoea AND one of the following:
Positive C. difficile toxin test OR results of C. difficile toxin test pending/Gene detected AND clinical suspicion of CDI

Discontinue non C. difficile antibiotics if possible to allow normal intestinal flora to be re-established. Confirmed and suspected cases must be isolated if living in communal areas, where practicable. For recurrent infection, review or stop PPIs unless required acutely.

Symptoms/signs of non-severe CDI
Oral Metronidazole 400 or 500mg TDS for 10-14 days

Daily assessment

Diarrhoea should resolve in 1-2 weeks
Recurrence occurs in ~ 20% of cases after first episode
Recurrence occurs in ~ 50-60% of cases after second episode

Symptoms not improving or worsening (treatment should not be deemed a failure until day 7 of treatment)

Contact microbiologists OR refer patient to hospital. Inform the admitting unit and complete infection risk transfer assessment.

Symptoms/signs of severe CDI
WCC >15, acute rising creatinine and/or signs/symptoms of colitis

Recurrence – within 30 days of previous case AND positive CDI toxin test, discuss with the microbiologist.

Anti-motility agents should not be prescribed in acute CDI

Severity

Mild CDI is not associated with a raised WCC; it is typically associated with <3 stools of types 5-7 on the Bristol Stool Chart per day.

Moderate CDI is associated with a raised WCC that is <15x10^9/L; it is typically associated with 3-5 stools per day.

Severe CDI is associated with a WCC >15x10^9/L, or an acute rising serum creatinine (i.e. >50% increase above baseline), or a temperature >38.5°C, or evidence of colitis (abdominal or radiological signs). The number of stools may be a less reliable indicator of severity.

Life-threatening CDI includes hypotension, partial or complete ileus or toxic megacolon, or CT evidence of severe disease.

N.B. Mild/moderate CDI – treat as non-severe.