Treatment algorithms

Algorithm 1. 1st episode of *Clostridium difficile* infection (CDI)

Diarrhoea AND one of the following:
Positive *C. difficile* toxin test OR Results of *C. difficile* toxin test pending
AND clinical suspicion of CDI

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If clinically appropriate discontinue non-*C. difficile* antibiotics to allow normal intestinal flora to be re-established
Suspected cases must be isolated

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Symptoms/signs: not severe CDI
(None of: WCC >15, acute rising creatinine and/or colitis)

Oral metronidazole
400mg 8-hourly 10-14 days

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DAILY ASSESSMENT

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Symptoms improving Diarrhoea should resolve in 1-2 weeks Recurrence occurs in ~20% after 1st episode; 50-60% after 2nd episode

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Symptoms not improving or worsening
Should not normally be deemed a treatment failure until day 7 of treatment. However, if evidence of severe CDI:
WCC >15, acute rising creatinine and/or signs/symptoms of colitis

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Switch to oral vancomycin 125 mg 6-hourly 10-14 days

Antimotility agents should not be prescribed in acute CDI

Symptoms/signs: *severe CDI*
WCC >15, acute rising creatinine and/or colitis
Oral vancomycin 125 mg 6-hourly 10-14 days. Consider oral fidaxomicin 200 mg 12-hourly 10-14 days in patients with multiple co-morbidities who are receiving concomitant antibiotics

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DAILY ASSESSMENT

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Symptoms not improving or worsening
Should not normally be deemed a treatment failure until day 7 of treatment. However, if evidence of severe CDI continues or worsens

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Surgery/GI/Micro/ID consultation

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AND, depending on degree of ileus/prior treatment
EITHER Vancomycin 125-500 mg PO/NG 6-hourly
+/- Metronidazole 500 mg IV 8-hourly x 10 days
OR Fidaxomicin 200 mg PO 12-hourly
PLUS CONSIDER Intracolonic vancomycin
(See protocol appendix 1 source document)

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Further Surgery/GI/Micro/ID consultation
Depending on choice of therapy (see above) consider:
1. High dose oral/NG vancomycin (500mg PO 6-hourly)
2. IV Immunoglobulin 400mg/kg 1 dose, consider repeat

Algorithm 2 Recurrent *Clostridium difficile infection* (CDI)

Recurrent CDI occurs in ~15-30% of patients treated with metronidazole or vancomycin

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Recurrence of diarrhoea (at least 3 consecutive type 5-7 stools) within ~30 days of a previous CDI episode AND positive *C. difficile* toxin test

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Must discontinue non- *C. difficile* antibiotics if at all possible to allow normal intestinal flora to be re-established
Review all drugs with gastrointestinal activity or side effects
(Stop PPIs unless required acutely)
Suspected cases must be isolated

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Symptoms/signs: not life-threatening CDI
Oral fidaxomicin 200 mg 12-hourly for 10-14 days
(efficacy of fidaxomicin in patients with multiple recurrences is unclear)
Depending on local cost-effectiveness decision making, Oral vancomycin 125 mg 6-hourly 10-14 days is an alternative

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Daily Assessment
(Include review of severity markers, fluid/electrolytes)

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Symptoms improving
Diarrhoea should resolve in 1-2 weeks

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IF MULTIPLE RECURRENCES ESPECIALLY IF EVIDENCE OF MALNUTRITION, WASTING, etc.

1. Review ALL antibiotic and other drug therapy (consider stopping PPIs and/or other GI active drugs)
2. Consider supervised trial of anti-motility agents alone*(no abdominal symptoms or signs of severe CDI)*

Also consider on discussion with microbiology:

3. Fidaxomicin (if not received previously) 200 mg 12-hourly for 10-14 days
4. Vancomycin tapering/pulse therapy (4-6 week regimen) *(Am J Gastroenterol 2002;97:1769-75)*
5. IV immunoglobulin, especially if worsening albumin status *(J Antimicrob Chemother 2004:53:882-4)*
6. Donor stool transplant *(Clin Infect Dis 2011;53:994-1002.Van Nood et al., NEJM 2013)*

Reproduced from: Updated guidance on the management of *Clostridium difficile* infection, Public Health England 2013
Disclaimer – refer to source document for full text.