CLINICAL PATHWAY:
Suspected *Clostridioides difficile (C. difficile)* Infection Evaluation and Management

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Inclusion Criteria: Suspected *Clostridioides difficile (C. difficile)* infection due to:
(1) prolonged or worsening diarrhea (at least 3 liquid stools in 24 hours; see Appendix A) **AND**
(2) risk factors for *C. difficile* infection (antibiotics in prior 3 months, hospitalization in prior 3 months, immunocompromised patients due to chemotherapy/humoral immunodeficiency/solid organ transplant, chronic inflammatory bowel disease, G-tube or J-tube need, use of acid suppressive therapies – PPI or H2 blockers, prior *C. difficile* infection, or at the discretion of the provider)
Exclusion Criteria: Soft or formed stools (see Appendix A), <3 liquid stools in 24 hours *(testing for C. difficile is NOT recommended in these cases; lab will reject stools that do not take shape of container)*

Place on Contact Precautions. Only send *C. difficile* testing if criteria met (see below).

Clinical Evaluation:
- When evaluating for possible *C. difficile* infection, note the age of the patient, number of liquid stools in the last 24 hours, presence of risk factors for *C. difficile* infection, relevant symptoms (e.g., abdominal pain, cramps, fever), vitals, WBC, and presence of tube feedings
- Vomiting is not characteristic of *C. difficile* infection and may signify an alternative diagnosis (e.g., viral gastroenteritis)
- Studies have shown that there is no characteristic odor of stool from patients with *C. difficile*

Considerations for testing for *C. difficile*:
- **<1 years of age:** Represents colonization
  - DO NOT test; treating for *C. difficile* is not indicated
- **1-2 years of age:** High likelihood of colonization; in rare circumstances, *C. difficile* infection may be possible – consider consulting Infectious Diseases
  - Evaluate for other infectious/non-infectious causes before testing for *C. difficile*
    - Add fiber to the formula of tube-fed patients
    - Stop medications associated with diarrhea (see Appendix A); laxatives/stool softeners should be stopped at least 48 hours prior to testing
- **>2 years of age:**
  - Test ONLY if patient has not received laxatives or other medications associated with diarrhea (or diarrhea persists after 48 hours of stopping the medication) AND at least 3 liquid stools in 24 hours AND if no alternative reason for diarrhea exists (see Appendix A for examples of medications)

Confirmed *C. difficile* infection:
- Testing algorithms may differ by lab – refer to the individual lab interpretation of results to determine if *C. difficile* infection exists [the test must include a positive toxin assay: PCR and/or enzyme assay (e.g., EIA)].
- *Repeat testing during the same episode is NOT recommended. Test of cure is not indicated because C. difficile colonization may persist.*

Initial Disease
(1st episode, or repeat episode >8 weeks from prior episode)

Treatment Options

Non-Severe Infection:
[diarrhea may contain some blood, WBC and SCr normal for age]
- <18 yrs old:
  - **Vancomycin PO**: 10 mg/kg/dose QID (max 125 mg/dose) **or**
  - **Metronidazole PO**: 7.5 mg/kg/dose TID (max 500 mg/dose) x10 days
- ≥18 yrs old:
  - Preferred: **Fidaxomicin** 200 mg/dose BID x10 days
  - Alternatives:
    - **Vancomycin PO**: 10 mg/kg/dose QID (max 125 mg/dose) **or**
    - **Metronidazole PO**: 7.5 mg/kg/dose TID (max 500 mg/dose) x10 days
  - If no improvement within 5-7 days: considered treatment failure. Follow guidelines under "Recurrent Disease".

Severe Infection:
[ill-appearing, diarrhea usually bloody, elevated WBC likely due to C. difficile]
- If <18 years old: **Vancomycin PO**: 10 mg/kg/dose QID (max 125 mg/dose) x10 days
- If ≥18 years old:
  - Preferred: **Fidaxomicin** 200 mg/dose BID x10 days
  - Alternative: **Vancomycin PO**: 10 mg/kg/dose QID (max 500 mg/dose) x10 days
- If no improvement within 5-7 days: consult GI and Infectious Diseases

Fulminant Infection:
[hypotension/shock due to C. difficile, ileus, mega colon; adults with serum lactate ≥5 mmol/L and peripheral WBC ≥50,000 associated with higher rates of mortality]
- **Metronidazole IV**: 7.5 mg/kg/dose q8hr (max 500 mg/dose) **and**
- **Vancomycin PO** 10 mg/kg/dose QID (max 500 mg/dose) **and/or**
  Vancomycin PR 4x/day via retention enema (through foley catheter clamped for 30-60 min retention time)
  - Do not use PR vancomycin if neutropenic
  - 1-4 yrs old: 250 mg in 50 mL normal saline
  - 4-11 yrs old: 375 mg in 75 mL normal saline
  - ≥12 yrs old: 500 mg in 100 mL normal saline
- Duration of treatment: 10 days
- Consults:
  - GI and Infectious Diseases
  - Consider Surgery consultation as needed

Recurrent Disease
(repeat episode ≤8 weeks from prior episode)

Treatment Options
[See disease severity under "Initial Disease" for clarification.]

1st recurrence:
- <18 yrs old:
  - **Metronidazole PO** 7.5 mg/kg/dose TID (max 500 mg/dose) x10 days **or**
  - **Vancomycin PO** 10 mg/kg/dose QID (max 125 mg/dose for non-severe infection; max 500 mg/dose for severe and fulminant infection) x10 days
- If ≥18 years old:
  - Preferred: **Fidaxomicin** 200 mg/dose BID x10 days
  - Alternative: **Vancomycin PO** (max 125 mg/dose for non-severe infection; max 500 mg/dose for severe and fulminant infection) x10 days

If second or more recurrence:
- Consult GI and Infectious Diseases
- If <18 years old:
  - Begin **Vancomycin with taper**: Vancomycin PO 10 mg/kg/dose QID (max 125 mg/dose for non-severe/severe infection, max 500 mg/dose for fulminant infection) x10 days *followed by taper*
    - *Example of a vancomycin taper:*
      - Vancomycin PO 10 mg/kg/dose (max 125 mg/dose) BID x7 days *followed by*
      - Vancomycin PO 10 mg/kg/dose (max 125 mg/dose) once daily for 7 days *followed by*
      - Vancomycin PO 10 mg/kg/dose (max 125 mg/dose) every 2-3 days for 2-8 weeks as directed by GI
- If ≥18 years old:
  - Preferred: **Fidaxomicin** 200 mg/dose BID x10 days
- If failure with above:
  - Consider options such as vancomycin + rifaximin, vancomycin + nitazoxanide, or fidaxomicin in consultation with GI and ID

Discharge Criteria: clinically stable, cleared by GI (and surgery/Infectious Diseases, if involved), ensure availability and insurance coverage of medication prior to discharge
Discharge Instructions: follow up with PCP and/or GI (if involved in hospitalization)

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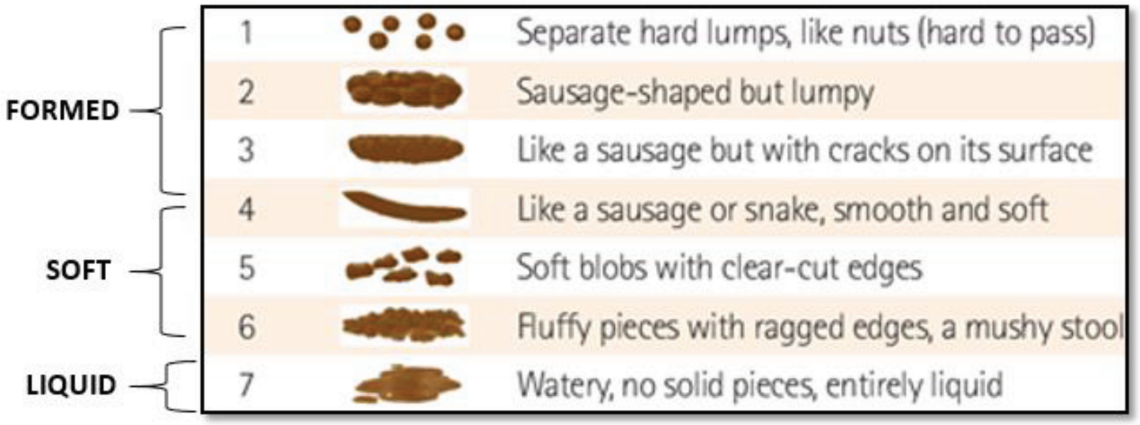
Bowel Consistency – Bristol Stool Chart



Examples of Medications That Can Cause Diarrhea

- Laxatives:
  - Lactulose, bisacodyl, magnesium citrate, docusate, Go-lytely, Senna, polyethylene glycol, sorbitol, etc.
- Enemas and suppositories
- Others:
  - Kayexalate
  - Colchicine
  - Octreotide
  - Metformin and other diabetic medications
  - Antibiotics
  - Antineoplastics
  - Magnesium containing antacids

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