NHS Sunderland
Clinical Commissioning Group

# Risk assessment for *Clostridium difficile* infection[i&iii]

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|---|---|---|
| T H I N K | **High risk patient** | • Older patients (>65)<br>• Long-term conditions requiring frequent antibiotics<br>• **AND** recent antibiotic exposure within previous 2 months |
| | **High risk environment** | • Previous contact with patients with *C.difficile*<br>• Recent hospital admission<br>• Institutionalised |
| | **High risk antibiotics** | The '4Cs'<br>• Cephalosporins<br>• Ciprofloxacin and other quinolones<br>• Clindamycin<br>• Co-amoxiclav and other aminopenicillins |
| | **Action** | • Withhold concomitant antibiotics (*non c.difficile*) if safe to do so - watchful waiting<br>• Avoid high risk antibiotics (the 4Cs)<br>• Prior history of HCAI: exercise caution when prescribing; avoid high risk agents; consult microbiologist for advice if necessary.<br>• **Stop** any laxatives.<br>• **Review** and stop any concomitant PPI use if possible (assess risk of stopping PPI). Re-start, if still required, when antibiotics are finished. |
| T E S T | **If develop diarrhoea** | • Suspect patient may be infective if no clear alternative cause for diarrhoea.<br>• Isolate patient and consult infection Prevention and Control Team.<br>• Gloves and aprons must be used for contact with patient and their environment.<br>• Hand wash with soap and water before and after contact with patient.<br>• Test stool for toxin |
| T R E A T | **Infection confirmed** | • **ALL** positive cases of C.difficile should be discussed with microbiologist prior to initiating treatment<br>• Initiate treatment oral metronidazole 400mg tds for 10-14 days **or** as advised by microbiologist<br>• Antibiotic therapy should be commenced as soon as possible, within 48 hours of prescribing<br>• If not improving or symptoms severe consult microbiologist<br>• **DO NOT** use antimotility drugs e.g. Loperamide<br>• Ensure ALL cases of C.difficile are **READ coded** as a major medical problem |

# Severity of *Clostridum difficile* infection[ii&iii]

**ALL positive cases of *C.difficile* should be discussed with Microbiologist prior to initiating treatment.**

| | Assessment of severity | Treatment |
|---|---|---|
| **Mild CDI** | Not associated with a raised WCC.<br><br>Typically associated with <3 stools of type 5 – 7 on the Bristol Stool Chart per day. | Where **metronidazole** is recommended:<br>400mg TDS for 10-14 days<br>(70% of patients respond to metronidazole in 5 days; 92% in 7 days)<br><br>Where **vancomycin** is recommended:<br>125mg caps QDS fro 10-14 days<br>(cannot be administered via PEG)<br><br>Note: microbiologist may recommend fidaxomicin 200mg BD for 10 days |
| **Moderate CDI** | Associated with a raised WCC that is <$15x10^9$/L.<br><br>Typically associated with 3 – 5 stools per day. | |
| **Severe CDI** | WCC > $15x10^9$/L<br><br>**OR** an acute rising serum creatinine (i.e. 50% increase above baseline)<br>**OR** a temperature of >38.5°C<br>**OR** evidence of severe colitis (abdominal or radiological signs).<br><br>Number of stools may be a less reliable indicator of severity. | Specialist treatment only. Admit as an emergency. |
| **Life-threatening CDI** | Includes hypotension, partial or complete ileus or toxic megacolon, or CT evidence of severe disease. | Specialist treatment only. Admit as an emergency. |

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[i] NHS South of Tyne and Wear *Risk Assessment for Clostridium difficile Infection* (July 2010)
[ii] Public Health England *Updated guidance on the management and treatment of Clostridium difficile infection* (May 2013)
iii North East & Cumbria antimicrobial prescribing guidelines v2.1