INTRODUCTION

The *Clostridioides difficile* management guideline establishes evidence-based standards for management of *C. difficile* infection (CDI) at UCSF Medical Center, San Francisco VA Medical Center, and Zuckerberg San Francisco General Hospital. The protocol has been adapted from published consensus guidelines from the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), and the American College of Gastroenterology (ACG) with input from the Antimicrobial Stewardship Program, the Infectious Diseases Management Program, and the Infectious Diseases division.

DEFINITIONS

Abbreviation	Definition
CDI	*Clostridioides difficile* infection
FMT	Fecal Microbiota Transplantation
ID	Infectious Diseases
GI	Gastroenterology

PRINCIPLES OF CDI MANAGEMENT

- Refer to the Hospital Epidemiology and Infection Control website for information on work-up of diarrhea and guidance on Infection Control issues pertaining to CDI at UCSF Medical Center (http://infectioncontrol.ucsfmedicalcenter.org/ucsf-clostridium-difficile-infection-prevention)
- Stop all unnecessary antibiotics, shorten antibiotic courses, and narrow the spectrum of antibiotic activity when possible
- Stop acid suppressive medications, especially proton-pump inhibitors, when possible
- Do not use anti-peristaltic agents until acute symptoms of CDI improve

TREATMENT OF CDI IN ADULT PATIENTS, INITIAL EPISODE

Clinical definition	Criteria	Treatment
Initial, non-complicated	Not meeting criteria for fulminant	Vancomycin 125 mg po q6h x 10 days In patients at very high risk for relapse (*C. difficile* toxin protein positive with signs of colitis PLUS advanced age, severe immunocompromise, or need for ongoing systemic antibiotics) and anticipate at least 5 days more in the hospital, could consider Fidaxomicin 200 mg po twice daily x 10 days* (be sure to check insurance coverage before prescribing for outpatients; if insurance does not cover can try the MERCK pt assistance program at www.merckhelps.com)

Fulminant	Hypotension, shock, ileus, and/or megacolon	Vancomycin 500 mg po/ng q6h + metronidazole 500 mg IV q8h +/- rectal vancomycin Rectal vancomycin should be considered in patients with ileus. It is given as 500 mg in 100 mL of 0.9% NaCl and instilled q6h (retain each dose for 1h) Consult ID and General Surgery for consideration of colectomy versus diverting loop ileostomy with colonic lavage

*Fidaxomicin is a restricted agent; can transition to po vancomycin for completion of course if unable to obtain outpatient

TREATMENT OF CDI IN ADULT PATIENTS, RECURRENT DISEASE

Recurrence is defined as the re-appearance of symptoms and signs of CDI within 8 weeks after completion of therapy for prior CDI episode for which symptoms and signs had resolved.

Clinical definition	Criteria	Treatment
1st recurrence	Except special populations below	Vancomycin taper: 125 mg po 4x daily x 14 days 125 mg po 2x daily x 7 days 125 mg po 1x daily x 7 days 125 mg po every other day x 8 days (4 doses) 125 mg po every 3 days x 2 weeks (5 doses)
1st recurrence, special population	Hematologic cancer with neutropenia expected > 30 days Recent bone-marrow transplant or treatment for GVHD Solid-organ transplant < 3 mths Otherwise not an FMT candidate	Fidaxomicin 200 mg po q12h x 10 days (be sure to check insurance coverage before prescribing for outpatients; if insurance does not cover can try the MERCK pt assistance program at www.merckhelps.com)
1st recurrence if initial occurrence treated with metronidazole		Vancomycin 125 mg po q6h x 10 days
≥ 2nd recurrence		Vancomycin taper (see 1st recurrence) PLUS Evaluate for FMT (for pts with ≥ 3 episodes) Consult ID, GI

SPECIAL SITUATIONS

Pediatric patients

Refer to: https://idmp.ucsf.edu/pediatric-guidelines-gastrointestinal-infections-clostridium-difficile-associated-diarrhea

Comment on probiotics

Mixed data exist regarding use of probiotics for primary prevention of CDI. There is insufficient data to support use for secondary prophylaxis. Can consider use based on patient and provider preference. Relatively contraindicated in immunocompromised populations.

Comment on duration of therapy in patients receiving ongoing antibiotics

Extension of CDI therapy in patients receiving ongoing systemic antibiotics is not routinely recommended. Can consider use based on patient and provider preference.

Comment on secondary antibiotic prophylaxis for CDI

Mixed data exist regarding use of vancomycin for secondary prevention of CDI. Can consider use based on patient and provider preference.

REFERENCES

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Original guideline prepared by:

UCSFMC: Sarah Doernberg, MD, MAS; Catherine Liu, MD; Jennifer Babik, MD, PhD; Rachel Wattier, MD; Alexandra Hilt-Horeczko, PharmD; Jonathan Faldasz, PharmD

SFVA team: Harry Lampiris, MD; Daniel Maddix, PharmD

ZSFG team: Lisa Winston, MD; Gregory Melcher, MD; Camille Beauduy, PharmD

2019 revision prepared by:

UCSFMC: Sarah Doernberg, MD, MAS

SFVA: Jennifer Mulliken, MD; Sean Chow, PharmD

ZSFG: Lisa Winston, MD; Camille Beauduy, PharmD

Approved by:

Group	**Date**
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