Management of Clostridioides difficile Infection (CDI)

Diagnosis

- Case definition: ≥3 unformed stools in a 24-hour period without an alternative explanation and a positive stool test for *C. difficile*.[1]
- Clinical spectrum of infection ranges from watery diarrhea with lower abdominal pain, cramping, and nausea (with or without low-grade fevers and leukocytosis) to severe or fulminant colitis.[2,3]
- Up to 50 percent of nursing home residents are colonized with *C. difficile* but are not actively infected.[2,4]
- Consider pre-emptive contact precautions while waiting for the results of *C. difficile* test results.[1]
- *C. difficile* testing recommendations[1]
  - Do not test formed stool samples.
  - Confirm the resident has not received a laxative in the previous 48 hours.
  - Confirm that the resident has not recently started or changed enteral nutrition (tube feeds).
  - Do not repeat testing within 7 days.
  - Do not perform tests of cure.

Treatment

- Residents with positive CDI tests who do not have symptoms of CDI should not be treated for CDI.[2,5]
- **Transfer residents with severe or fulminant CDI to an acute care setting.**[1,6]
  - Severe CDI: WBC ≥15,000 cells/mL OR acute increase in serum creatinine to ≥1.5 mg/dL OR acute kidney injury associated with CDI.
  - Individuals with severe disease may have ileus without stool output; they generally have colitis identified on imaging, abdominal pain/distention, and systemic illness.
  - Fulminant CDI: hypotension or shock, intestinal perforation, toxic megacolon.
- **Nonsevere CDI**
  - Oral vancomycin (125 mg orally [PO] 4 times a day) or fidaxomicin (200 mg PO 2 times a day) for 10 days.
  - If access to oral vancomycin or fidaxomicin is limited, consider oral metronidazole (500 mg PO 3 times a day) for 10 days.[1]
  - Discontinue antibiotics not needed for CDI treatment whenever possible.[1]
  - If antibiotic therapy is still needed, select the narrowest agent possible and avoid agents with a strong association with CDI (i.e., fluoroquinolones, clindamycin, and third- and fourth-generation cephalosporins).[7]
  - Discontinue gastric-acid suppression medications whenever possible.[2,8]
  - Avoid antimotility agents.[1,9,10]
- **Recurrent CDI**
  - About 25 percent of people have recurrent CDI. Recurrent disease may be nonsevere, severe, or fulminant. The risk of recurrence increases with age.[1,2,11,12]
  - Avoiding systemic antibiotics is the best way to prevent recurrent CDI.[1]
  - Loose or soft stool may persist for weeks to months following treatment for CDI.[13,14]
  - For residents who meet the case defintion (≥3 unformed stools in a 24-hour period without an alternative explanation), retest to confirm the diagnosis.[1]
  - If metronidazole was used for the initial episode, consider oral vancomycin (125 mg PO 4 times a day).
  - If oral vancomycin was used for the initial episode, consider fidaxomicin (200 mg PO 2 times a day) for 10 days OR tapered oral vancomcyin (125 mg PO 4 times a day for 10–14 days, 2 times per day for 7 days, 1 time per day for 7 days, every 2–3 days for 2–8 weeks).

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