

Management of *Clostridium difficile* infection

Patient Name:

MRN:

(Cross off the inappropriate definition below)

1. *C. difficile* toxin has been detected in this patient, **specimen number**
2. Pseudomembranous colitis (PMC) revealed by lower gastrointestinal endoscopy dated
3. Colonic histopathology characteristic of *C. difficile* infection on a specimen obtained during endoscopy, colectomy or autopsy specimen number

The clinical spectrum ranges from asymptomatic carriage, to mild antibiotic associated diarrhoea and acute severe potentially fatal pseudomembranous colitis. It is essential to assess *C. difficile* toxin positive patients carefully and to consult with surgical/gastroenterology colleagues as necessary.

Treatment

- Stop all unnecessary antibiotics or change broad-spectrum to narrow-spectrum antibiotics. Please discuss with a medical microbiologist as required. If antibiotics are necessary, please keep treatment duration as short as possible.
- Ensure the patient is adequately rehydrated, either through the oral or intravenous route.
- Treat with oral metronidazole, 400mgs t.d.s for 7-10 days, unless the diarrhoea has stopped. Please discuss with a medical microbiologist if the oral route is not available or if metronidazole has already failed.
- When symptoms have settled, antibiotics should be used judiciously in the future. It may be appropriate to liaise with the GP to this effect
- If severe *C. difficile* infection is suspected (see below)
 1. Obtain a surgical opinion
 2. Commence oral vancomycin 250mg QDS (rather than metronidazole)
 3. Contact one of the microbiologists.

Severe *C. difficile* Infection

Stool frequency \geq	8 stools a day	Colonic dilation on CT
Temperature	\geq 38°C	Lower GIT haemorrhage
WCC	\geq 20X10 ⁶	Perforation
Lactate	> 5	Septic shock
		Renal dysfunction

Isolation

- **The patient should be placed in a single room with dedicated equipment until at least 48 hours without diarrhoea and has had a formed or normal stool.**
- If there is no single room available, patients may be cohorted with other patients with *C. difficile* infection. However this should be undertaken only following a risk assessment and discussion with the consultant microbiologist and the patient's consultant.
- Standard precautions should be adopted i.e. hand hygiene, protective clothing, gloves etc when caring for the patient. Hand washing with soap and water or chlorhexidine is essential. Alcohol hand gel is not effective against *C. difficile* spores
- If the patient cannot be isolated, a risk management form should be compiled by the ward manager and the other stated precaution measures rigorously implemented. The patient should have a designated commode for their use only. **Please note:** The patient remains infectious for as long as diarrhoea persists.

Environmental Cleaning

Environmental decontamination with Teepol and Prescept (hypochlorite 10,000 ppm) on a daily basis. After discharge, a further thorough cleaning should be carried out and the curtains changed.

C. difficile testing

Once a diagnosis of *C. difficile* is confirmed in the laboratory, there is no requirement to continue to check for the presence of toxin in the stool as the stool can remain toxin positive for some time. Furthermore, this is time consuming and wasteful. Further stools should **only** be sent if the patient, having responded to treatment, appears to have relapsed and developed a recurrence of diarrhoea, four weeks or later after the initial diagnosis.

Please contact one of the medical microbiologists or a member of the Infection Prevention & Control Team for further advice as required

Date/...../.....