CHI Memorial
Clostridioides difficile Infection (CDI) Clinical Pathway

Principles of CDI Management

- Stop all unnecessary antibiotics, shorten antibiotic courses, and narrow the spectrum of antibiotic activity when possible
  - Consider discussion with ID Physician or ASP Pharmacist (x7536)
- Stop acid suppressive medication when possible, especially proton-pump inhibitors
- Discontinue all anti-motility agents

Treatment Recommendations

Clinical definition	Criteria	Management
Initial episode, non-fulminant, no risk factors		• Vancomycin 125mg PO q6 hours x 10 days
Initial episode, non-fulminant & ≥1 risk factors for recurrent infection	• Age ≥ 65 • Severe immunosuppression • Concomitant systemic antibiotic(s) that cannot be stopped • NAP1/BI/027 strain (+)	• Vancomycin taper
First recurrence, non-fulminant	New onset of CDI symptoms within 3 months of previous episode	• Vancomycin taper **OR** • Fidaxomicin(ID restricted) 200mg PO BID x 10 days or pulsed, especially for patients who used a PO vancomycin taper for first episode or ≥1 risk factors for recurrent infection
Second or subsequent recurrence, non-fulminant		Consider ID Consult • Vancomycin taper **OR** • Fidaxomicin(ID restricted) 200mg PO BID x 10 days or pulsed
Fulminant episode, any occurrence	Hypotension, shock, ileus, or megacolon	Consult ID & Surgery Consults **AND** • Vancomycin 500 mg given PO q6 hours x10 days **AND** • Metronidazole 500 mg IV q8 hours until resolution of ileus (if present) and hemodynamically stable (up to 10 days) **AND/OR** • If ileus present: Vancomycin 500 mg/100 mL NS retention enemas PR Q 6 hours x 10 days

- Vancomycin taper: Vancomycin 125 mg PO Q 6 hours x 14 days, then 125 mg Q 8 hours x 7 days, 125 mg Q 12 hours x 7 days, 125 mg Daily x 7 days, 125 mg Q2D x 7 days
- Fidaxomicin: requires approval by ID/ASP and drug affordability check with case management prior to inpatient administration. Alternative dosing of fidaxomicin can be considered and may further reduce recurrent CDI (200mg PO BID x 5 days, then once every other day for 20 days)

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Adjunctive Therapies

- **Bezlotoxumab** (10mg/kg (max: 1,000mg) x 1 dose during administration of active CDI treatment): Adjunctive therapy to prevent recurrent CDI. Use caution in patients with underlying congestive heart failure (CHF). Restricted to outpatient infusion use (if approved) for patients with any of the following risk factors:
  - ≥ 65 years old
  - History of one or more CDI episode in the past 6 months
  - Immunocompromised status
  - ≥2 points on the Zar score for severity
    - 1 point each is given for age >60 years; temperature >38.3°C; albumin level <2.5 mg/dL; WBC count >15,000 cells/mm3
    - 2 points are given for endoscopic evidence of pseudomembranous colitis; treatment in ICU
- **Fecal Microbiota Transplantation (FMT):** consider in patients with ≥2 recurrences of CDI. Discuss with GI &/or ID physicians
- **Secondary prophylaxis:** Oral vancomycin prophylaxis (OVP) may be considered for patients with a history of CDI (within last 3 months) who require systemic antibiotic therapy. Consider dosing vancomycin at 125mg PO daily until 5 days post completion of systemic antibiotics. OVP may be most beneficial in patients who are at high risk for recurrence: ≥ 65 years old, significant immunocompromise, or those with a history of severe CDI
- **Probiotics:** Mixed data exist regarding use of probiotics for primary prevention of CDI. There is insufficient data to support use for secondary prophylaxis. Routine use is discouraged.

Comments

- There is no evidence to support dual therapy with ORAL Flagyl & ORAL Vancomycin (only IV Flagyl + PO Vanco)
- No need to repeat *Clostridioides difficile* testing for test of cure