GUIDANCE AT A GLANCE - *CLOSTRIDIUM DIFFICILE*

These guidelines support the control and prevention of *C.difficile* in community and primary care settings.
Key Ref: PHE (2013) Updated guidance on the management and treatment of *Clostridium difficile* infection

KEY POINTS

- Early diagnosis prevents complications and saves lives
- Prudent prescribing of antibiotics may prevent infection
- Communication of infection risk helps prevent cross infection
- Alcohol hand rub is **ineffective** at killing *C.difficile* spores.
- Review Risk factors for infection = over 65's, recent hospitalisation, recent antibiotics, GI procedures and gastric ulcer medications

These affect the balance of bacteria in the bowel providing an opportunity for C.difficile to multiply, produce toxin and inflame the bowel

ANTIBIOTICS

My patient has diarrhoea

A useful mnemonic protocol for potentially infective diarrhoea is :
Suspect that a cause may be infective where there is no clear alternative cause of diarrhoea or the patient has recently received antibiotics
Isolate the patient if appropriate – *i.e. care home residents*
Gloves and aprons must be worn to reduce cross contamination
Hand washing with soap & water before and after each patient contact and the patient's environment
Test the stool for toxin, by sending a specimen immediately

Watery or mucoid diarrhoea with or without blood (typical smell and green appearance), abdominal pain, loss of appetite, fever.

CDI Symptoms

My patient has confirmed CDifficile Infection

- **No repeat specimens** are required once diagnosed. For **toxin gene detected** results, only treat as C.difficile infection (CDI) if symptomatic.
- Review the need for any current antibiotics and stop the course if possible – if unable to stop, change to a narrow spectrum antibiotic.
- Review other drugs that may potentially cause diarrhoea.
- Proton pump inhibitors (PPI) should be reviewed/reduced where possible
- For treatment options refer to the algorithm over the page and also the local antimicrobial guidelines for primary care.
- Maintain hydration, monitor diarrhoea *(for care homes residents, advice care plan, fluid balance chart and Bristol Stool Chart to support this)*
- Where patients/carers are unable to manage due to the symptoms of *C.difficile* consider referral to social services.

Communicating infection risk:

- If admitting a patient with symptoms, notify the receiving area so appropriate isolation can be instigated.
- The IPC team will write to your patient supplying a leaflet and card with information – copied to the practice.
- Record the infection risk on the patient record as guided by the IPC team.

CDI can lead to: dehydration, electrolyte imbalance low blood albumin pseudomembranous colitis, toxic megacolon, sepsis , death.

Complication

My patient has a history of CDifficile and needs antibiotics

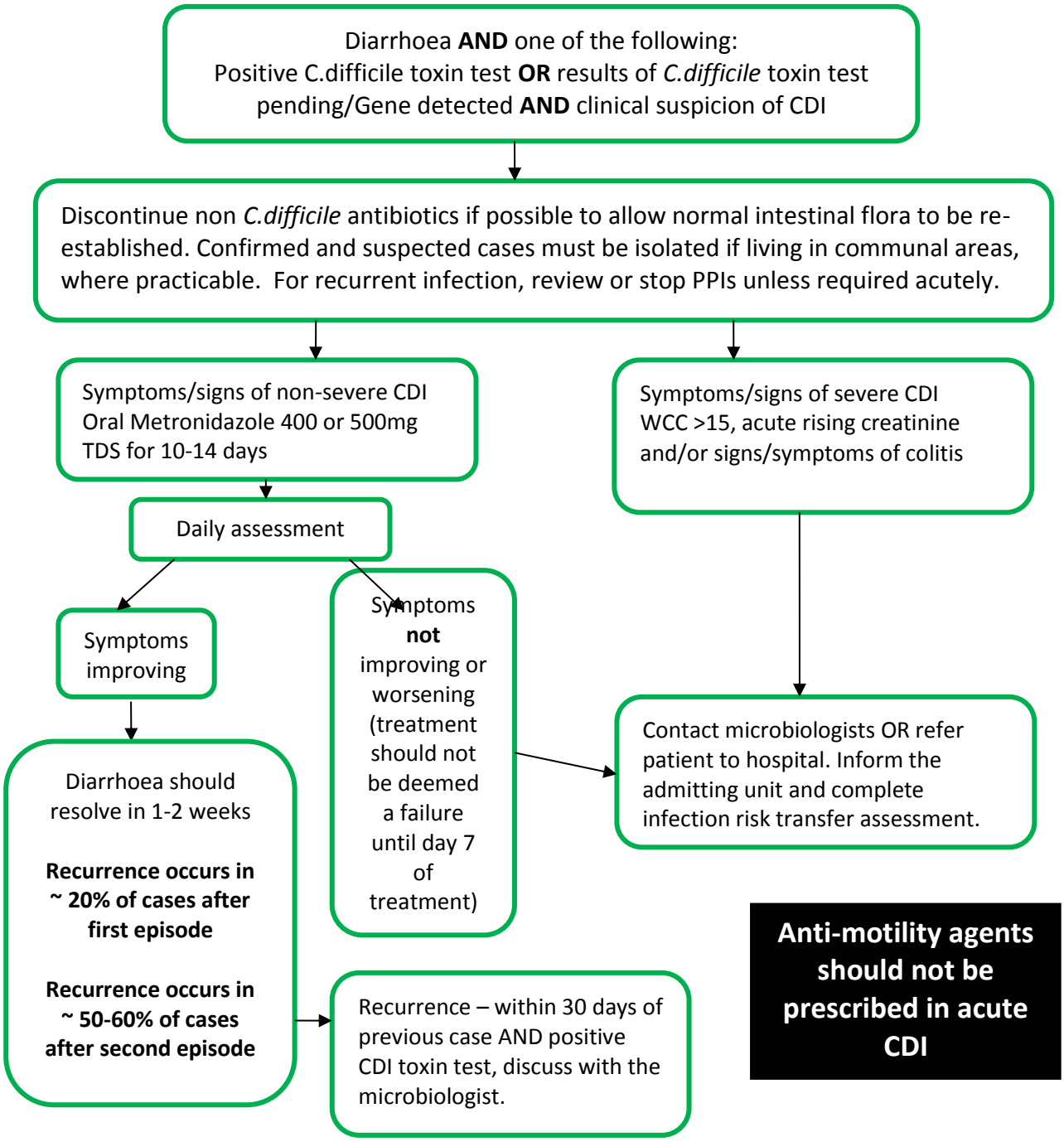
There is an increased risk of CDI if someone has had it before or has had the gene detected. Consider narrow spectrum antibiotics if treating other infections

Resources

- Antimicrobial guidelines
- Patient held card
- CDifficile patient information leaflet
- PHE guidelines '13

Infection Prevention and Control Team for resources and advice on Tele: 01484 225598 or infection.control@kirklees.gov.uk
Microbiologist for prescribing and treatment advice (SWITCHBOARD) CHFT – 01484 342000, MYHT – 08448 118110
Thanks to Calderdale IPC team for allowing adaptation of this guidance

Treatment Algorithm for CDI



Severity

Mild CDI is not associated with a raised WCC; it is typically associated with <3 stools of types 5-7 on the Bristol Stool Chart per day.
Moderate CDI is associated with a raised WCC that is <15x10^9/L; it is typically associated with 3-5 stools per day.
Severe CDI is associated with a WCC >15x10^9/L, or an acute rising serum creatinine (i.e. >50% increase above baseline), or a temperature >38.5˚C, or evidence of colitis (abdominal or radiological signs). The number of stools may be a less reliable indicator of severity.
Life-threatening CDI includes hypotension, partial or complete ileus or toxic megacolon, or CT evidence of severe disease.
N.B. Mild/moderate CDI – treat as non-severe.

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