Pathway inclusion criteria:
Inpatient, confirmed or high suspicion of C. difficile infection (CDI)

Positive C. diff test **-AND-** clinical signs/symptoms consistent with CDI
-OR-
High clinical suspicion
(e.g. fever, high white blood cell (WBC) count;
≥ 3 documented liquid stools in 24 hours)
For additional information, see Penn Medicine Antimicrobial Stewardship site

Support for this PennPathway was provided by the Penn Medicine Center for Evidence-based Practice

Contact Nikhil Mull, MD or Emilia Flores, PhD, RN for more information on our PennPathways program.

This PennPathway was developed using a multidisciplinary approach and presents the best model of care based on the best available scientific evidence the time of publication. Recommendations are not intended to replace professional judgement.

Copyright 2018 by the Trustees of the University of Pennsylvania. All rights reserved. No part of this publication may be reproduced without permission in writing from the Trustees of the University of Pennsylvania.

If possible, STOP precipitating antibiotic(s), laxatives, acid-suppression agents, anti-peristaltic agents

- Discontinue therapy with **ANY** other systemic antibiotic agent(s) as soon as possible, as this may influence the risk of CDI recurrence.
- STOP all laxatives immediately to reduce risk of prolonged diarrheal illness
- STOP and AVOID anti-peristaltic agents (eg loperamide, Lomotil) throughout treatment course
- STOP and AVOID unnecessary proton pump inhibitors (PPI)

Sepsis recognition tool

PENN SEPSIS RECOGNITION TOOL

SEPSIS WITHOUT ORGAN DYSFUNCTION — SEPSIS WITH ACUTE ORGAN DYSFUNCTION — SEPTIC SHOCK

Determine if CDI is fulminant

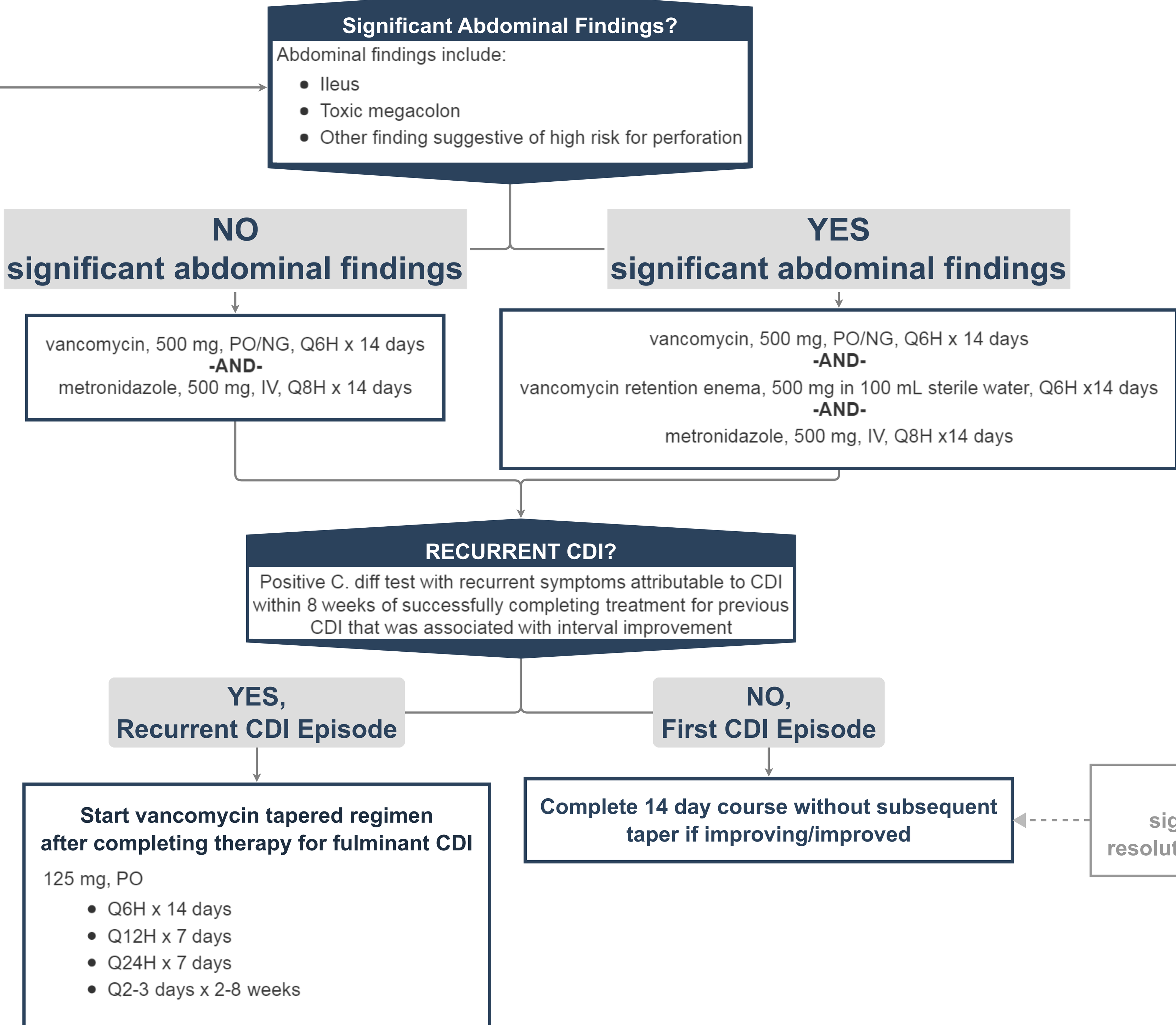
CDI is fulminant if

- CDI is the cause of sepsis with acute organ dysfunction or septic shock without other identifiable etiology
  -OR-
- Abdominal signs/symptoms (vomiting, distension) concerning for ileus or toxic megacolon

Not fulminant | **YES, Fulminant**

Management of fulminant CDI

- Antibiotic therapy should be started empirically
- Order a C. difficile test to confirm infection
- Obtain one view abdominal x-ray upright portable
  - Consider CT abdomen/pelvis (ideally with IV and PO contrast as tolerated) is recommended if abdominal distension consistent with signs / symptoms (vomiting, distension) of ileus, toxic megacolon
- Surgical -AND- infectious disease (ID) consults recommended



Confer with ID if patient had significant abdominal findings or slow resolution, to consider course beyond 14 days

CDI recurrence?

Recurrence is defined as:
Positive C. diff test with **recurrent symptoms** attributable to CDI **within 8 weeks of successfully completing treatment** for previous CDI that was associated with interval improvement

NO, First CDI Episode | **YES, Recurrent CDI Episode**

Intolerance/allergy to oral vancomycin

Consider fidaxomicin, 200mg, 2x day, 10 days;
or metronidazole 500 mg, 3x/day, 10 days,
or infectious diseases (ID) consult

Non-fulminant

Therapy	Notes
vancomycin 125 mg, PO, Q6H x 10 days*	*If the patient is currently receiving other systemic antibiotics, consider extending the CDI treatment course for 7 additional days beyond the final day of systemic antibiotics (minimum 10 day CDI course)

First Recurrence

Select ONE

vancomycin	vancomycin tapered regimen
125 mg, PO Q6H x 10 days (Use especially if your patient was treated previously with metronidazole)	125 mg, PO • Q6H x 14 days • Q12H x 7 days • Q24H x 7 days • Q2-3 days x 2-8 weeks

Multiple recurrences

vancomycin tapered regimen
125 mg, PO
- Q6H x 14 days
- Q12H x 7 days
- Q24H x 7 days
- Q2-3 days x 2-8 weeks

Intolerance/allergy to oral vancomycin

Consider fidaxomicin, 200mg, 2x day, 10 days;
or infectious diseases (ID) consult

Consult infectious disease (ID) for consideration of fecal microbiota transplantation (FMT)

Evaluation for **FMT is recommended** for patients with 2+ recurrences of CDI

If no improvement in diarrhea within 5 DAYS

- Consider alternative causes for infection
- Consider non-infectious etiologies for diarrhea such as recent initiation of enteral nutrition or medication related effects
- If above evaluation is unrevealing, consider refractory CDI; consult ID