Clostridioides difficile in the Community Guideline

Bristol, North Somerset and South Gloucestershire Integrated Care Board

Acute diarrhoea presenting in the community - suspect *C.difficile* if any of the following present:

- Diarrhoea is not clinically attributable to any other cause (e.g. laxatives)
- Currently prescribed or has recently had a course of antibiotics (risk persists for up to 90 days)
- Is or has been a hospital inpatient or resident in an institution (risk persists for up to 60 days)

If *C.difficile* infection (CDI) is suspected then request a stool sample for routine culture as well as for *C.difficile* toxin testing. (Note – *C.difficile* toxin testing is not undertaken in those aged under 2 years) See page 2

If positive *C. difficile* toxin test OR results of *C.difficile* toxin test pending AND high clinical suspicion of CDI

- If possible, discontinue all antibiotics other than those prescribed for CDI. If the patient has severe infection or clinical sepsis, discuss case with a medical microbiologist.
- Review hydration & consider electrolyte replacement if appropriate
- Inform the patient of result and give advice on maintaining stool chart and give patient info leaflet.

- Do not start any anti-motility drugs e.g. loperamide
- Stop any current anti-motility /anti-diarrhoeal drugs e.g. opioid analgesics if possible
- Review any treatment with PPIs and medication that may cause problems if people are dehydrated eg NSAIDs

Adults – consider discussing treatment with a medical microbiologist

Children –treatment must be discussed with a medical microbiologist or infectious diseases specialist

Assess severity – review stool type and frequency, abdominal pain, distension, temperature and white cell count where possible. Also consider the likelihood of a patient to maintain hydration.

Symptoms/ signs of **mild or moderate** CDI
Vancomycin 125mg qds 10days

Review after 7 days or sooner if symptoms are worsening

Symptoms improving – complete 10 days course Diarrhoea should resolve in 1-2 weeks

Symptoms not improving or evidence of severe CDI – discuss alternative treatment / need for admission with a medical microbiologist

Symptoms/ signs of **severe** CDI:
WCC>15, acute rising creatinine, temperature>38.5°C and/or signs/ symptoms of colitis (e.g. bloody diarrhoea, distended abdomen) OR if **patient acutely unwell**

Discuss treatment options with a Medical Microbiologist **urgently** / consider admitting to hospital for assessment. Ensure the admitting team is informed that the patient has suspected or confirmed CDI to ensure appropriate infection control measures are enforced.

Further episode within 12 weeks of symptom resolution (**Relapse**)
No need to retest if within 28 days.
Discuss treatment with a medical microbiologist.

Further episode more than 12 weeks after symptom resolution (**recurrence**).
If less severe or first recurrence episode or has been a long time between episodes Vancomycin 125mg qds 10 days
If more severe, more recent or multiple recurrent episodes discuss with a medical microbiologist

Counselling: fluid to avoid dehydration, preventing spread, seek medical help if symptoms worsen rapidly or significantly at any time

- **Future courses of antibiotics for patients with previous CDI should be considered carefully**. Discussion with microbiology may be considered in these cases.
- Infection control – Inform Healthcare Professionals involved in the patient's care about the patient's diagnosis to reduce risks. Local infection control policies should always be followed. Alcohol hand gel is not sufficient for *C. difficile* spores - Wash hands thoroughly with soap, water and dry well
- Vancomycin capsules are kept in stock in pharmacies signed up to the NHSE Specialist Medicines LES
- Ensure *C.difficile* is coded in the patient's notes SNOMED code:186431008

Microbiological advice can be obtained from:
0117 4146222 option 1 - UHBristol option 2 – NBT and Weston

DRAFT Version 8.0 Updated April 2025 Review due April 2028 Ref NICE NG199

Testing for Clostridioides difficile

If a patient has diarrhoea (Bristol Stool Chart types 5-7) that is not clearly attributable to an underlying condition (e.g. inflammatory colitis, overflow) or therapy (e.g. laxatives, enteral feeding) then it is necessary to determine if this is due to Clostridioides difficile (CDI), also known as "C.diff". Diarrhoeal samples should be tested for C.difficile from all community patients aged >65 years, and from community patients aged <65 years wherever clinically indicated.

The stool sample must take on the shape of the container and ideally be at least ¼ filled (to indicate the patient has diarrhoea) before it is sent to the laboratory for testing.

The laboratory now undertakes a two-stage testing algorithm to detect the presence of C.difficile toxins, as illustrated below

C.difficile testing result on unformed stool (Bristol Stool Chart types 5-7)		
Test	**Result**	**Interpretation**
C.difficile toxin B PCR	DNA not detected	CDI is very unlikely. Patient could have other potential pathogens. No further C.difficile-specific tests will be undertaken on this sample
OR		
C.difficile toxin B PCR	DNA detected	This indicates that the sample contains C.difficile toxin B DNA. A second test is performed to detect the presence of C.difficile toxin antigens (toxin A/B).
C.difficile toxin B PCR will be followed by C.difficile toxin antigen testing		
C.difficile toxin B PCR	DNA detected	
C.difficile toxin antigen	Negative	No detectable C.difficile toxin A/B. The patient is colonised with a toxigenic strain of C.difficile, but in the absence of detectable toxin A/B the symptoms are likely to be due to another cause. Treatment is generally not recommended but if the symptoms/ signs are not consistent with the result then discussion with a medical microbiologist is advised
OR		
C.difficile toxin B PCR	DNA detected	
C.difficile toxin antigen	Positive	Consistent with C.difficile infection.