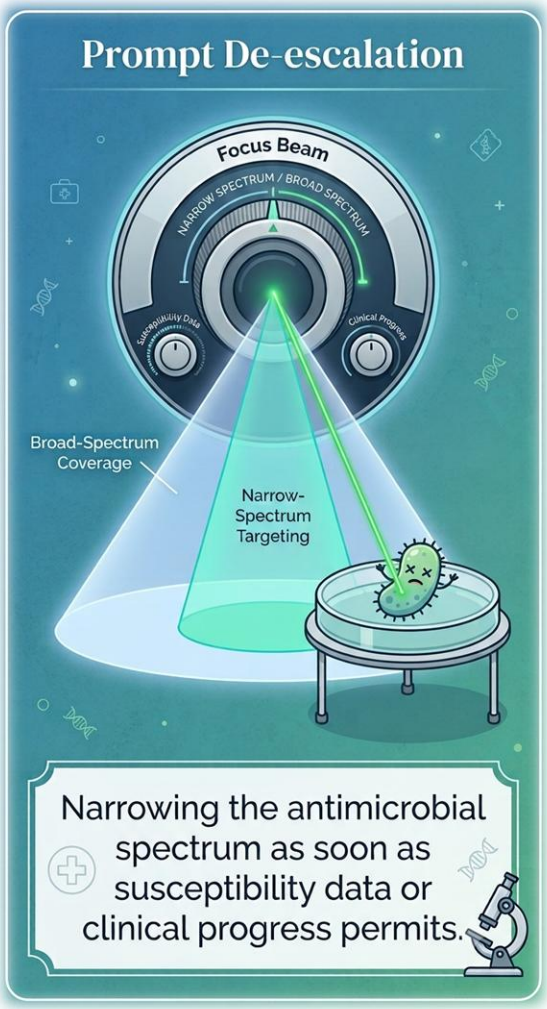
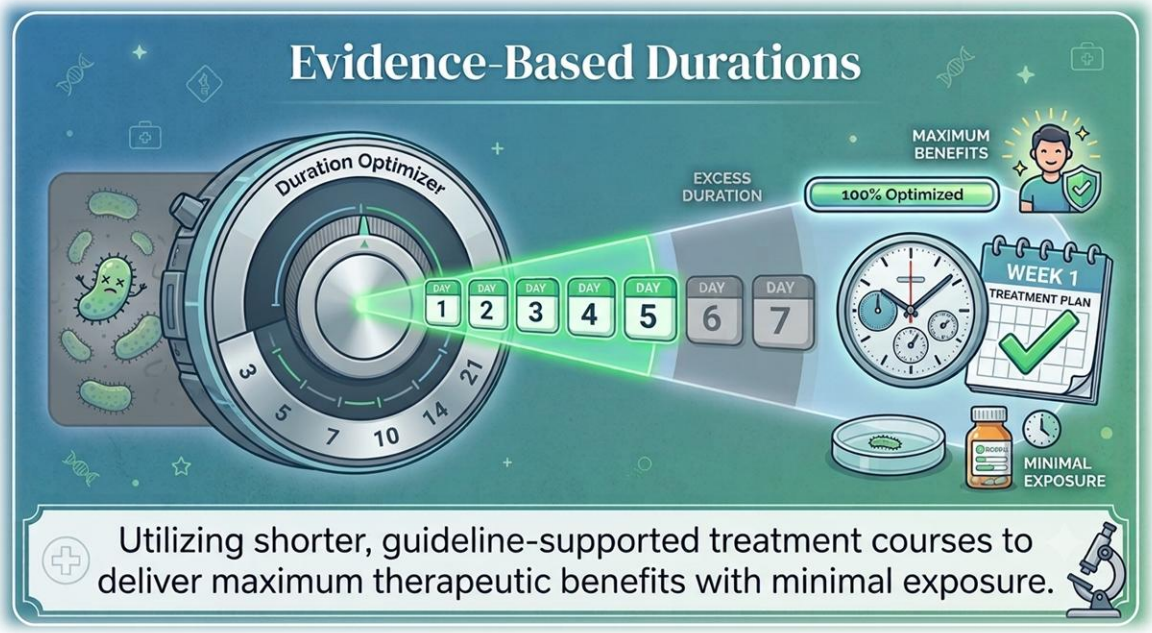
AUG 2026

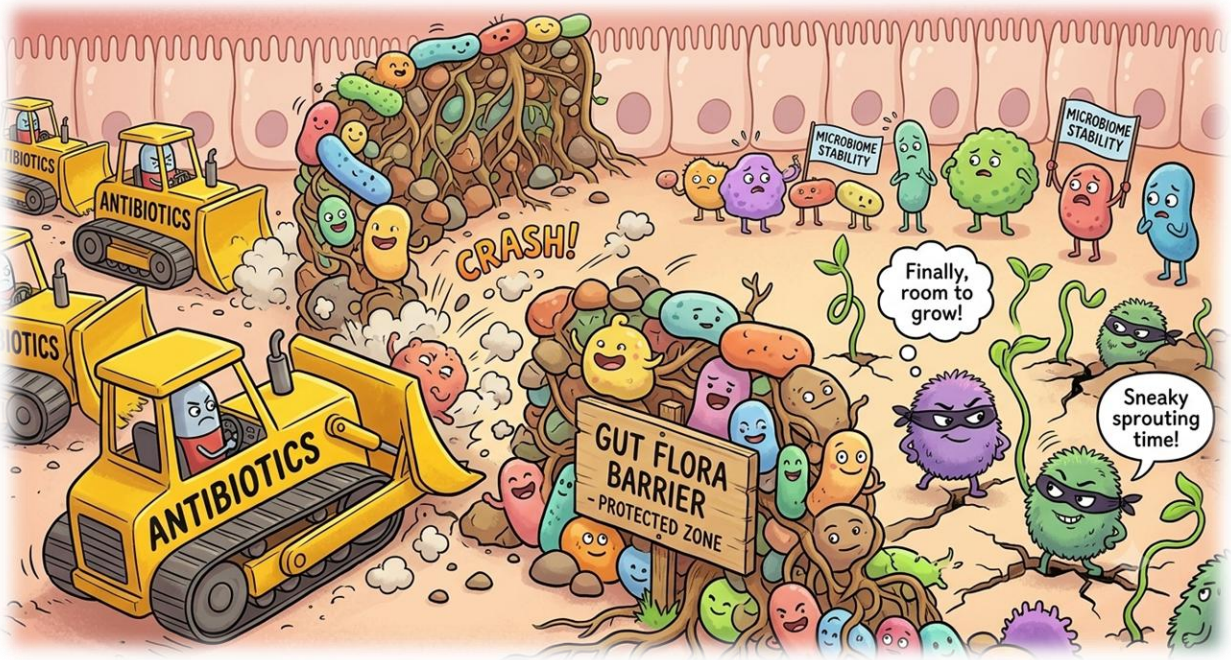
Finding the Balance:
Why Every Dose Counts for CDI Prevention

Treating acute bacterial infections is essential and frequently life-saving work. Concurrently, protecting the gut microbiome from unnecessary disruption is increasingly recognized as a key facet of comprehensive patient care. Many clinicians already routinely balance these dual priorities, identifying the clinical "tipping point" during daily ward rounds—that moment when an infection is securely controlled and the focus can safely shift to minimizing further antimicrobial exposure.


Stop "Just in Case" Dosing
STOPPING therapy promptly once stability is achieved is an important act of patient protection.
THERAPY EXTENSION
LAST DAY DOSE
EXTRA DAY
EXTRA DAY
OPTIMIZED
100%
OUTCOMES
EFFICIENCY


Prompt De-escalation
Focus Beam
NARROW SPECTRUM / BROAD SPECTRUM
Susceptibility Data
Clinical Progress
Broad-Spectrum Coverage
Narrow-Spectrum Targeting
Narrowing the antimicrobial spectrum as soon as susceptibility data or clinical progress permits.


Evidence-Based Durations
Duration Optimizer
3
5
7
10
14
21
EXCESS DURATION
MAXIMUM BENEFITS
100% Optimized
DAY 1
DAY 2
DAY 3
DAY 4
DAY 5
DAY 6
DAY 7
WEEK 1
TREATMENT PLAN
MINIMAL EXPOSURE
Utilizing shorter, guideline-supported treatment courses to deliver maximum therapeutic benefits with minimal exposure.

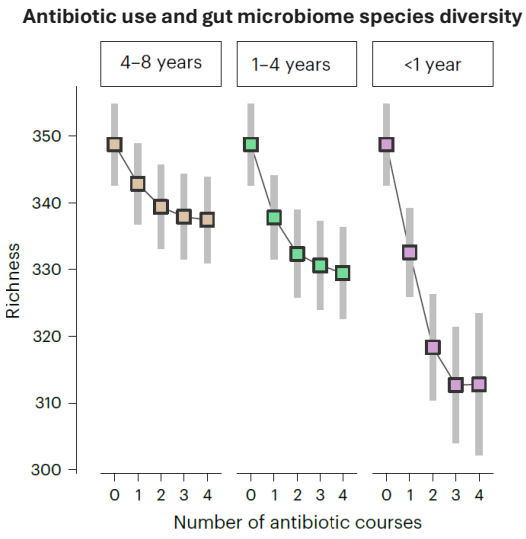


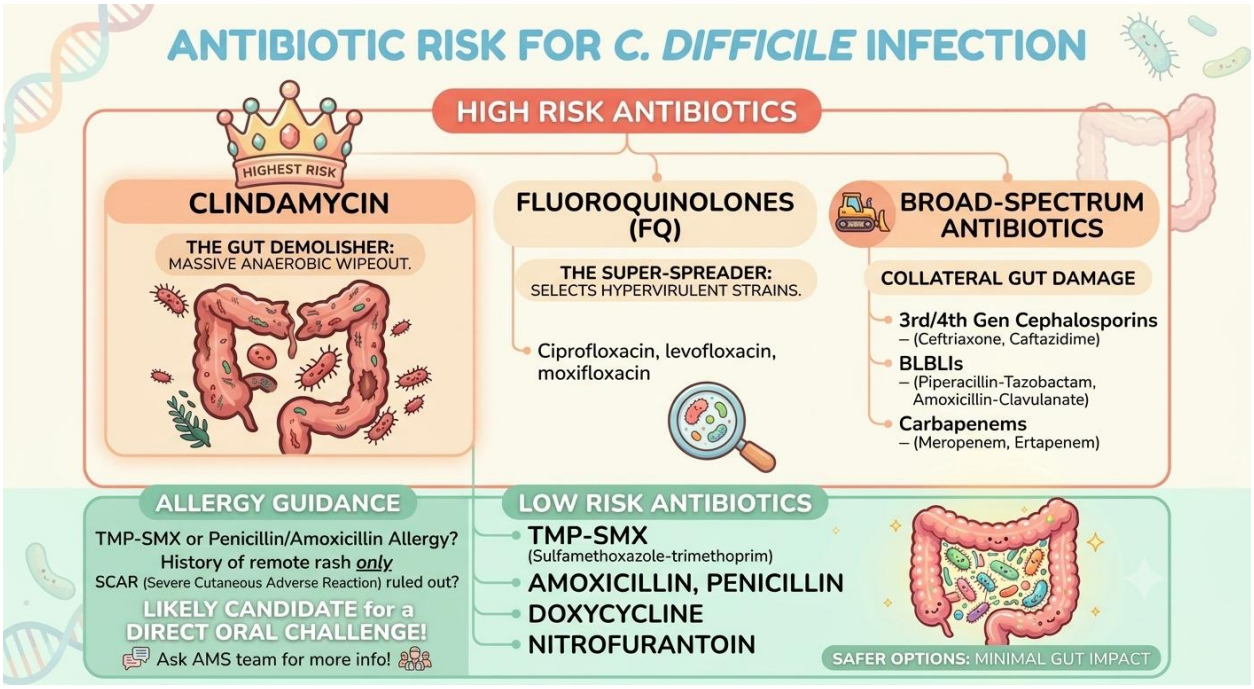
CDI is a Disease of Dysbiosis

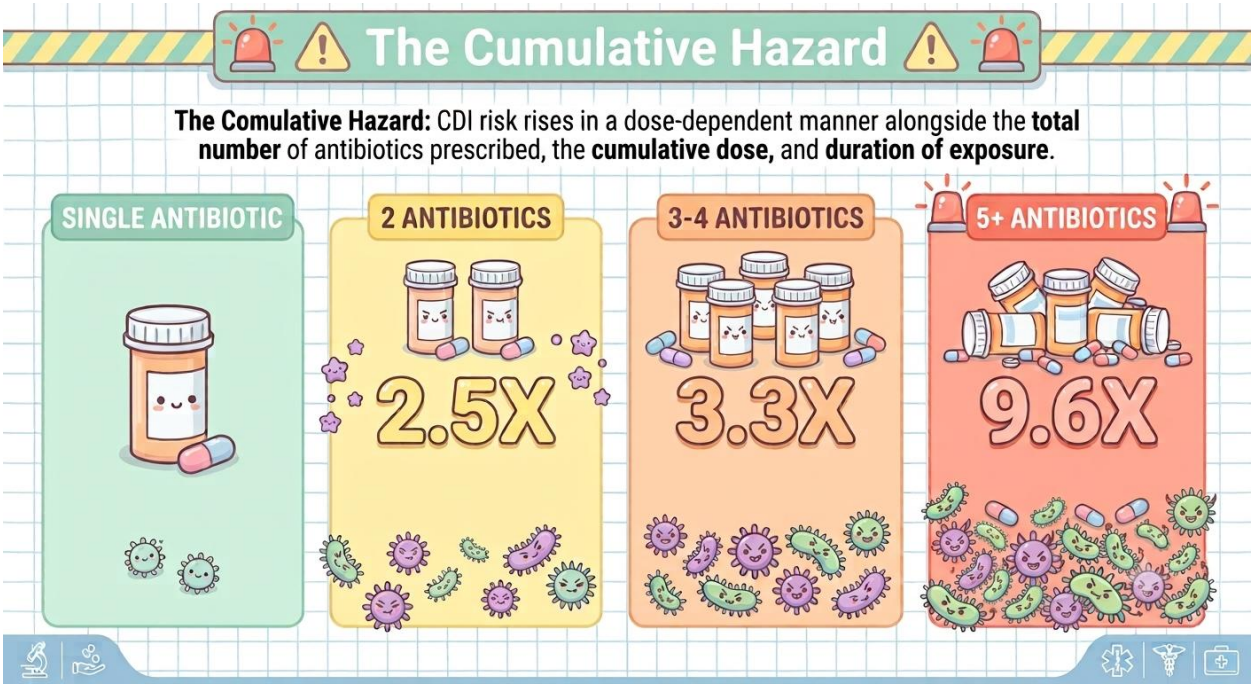
- While *Clostridioides difficile* is a Gram-positive, spore-forming bacterium responsible for severe, toxin-mediated colitis, the root cause of the infection is dysbiosis.
- When antibiotics destroy the natural flora barrier, resilient *C. difficile* spores germinate and proliferate unchecked, turning an opportunistic threat into active colitis.

The Lost Microbiome Diversity [1]

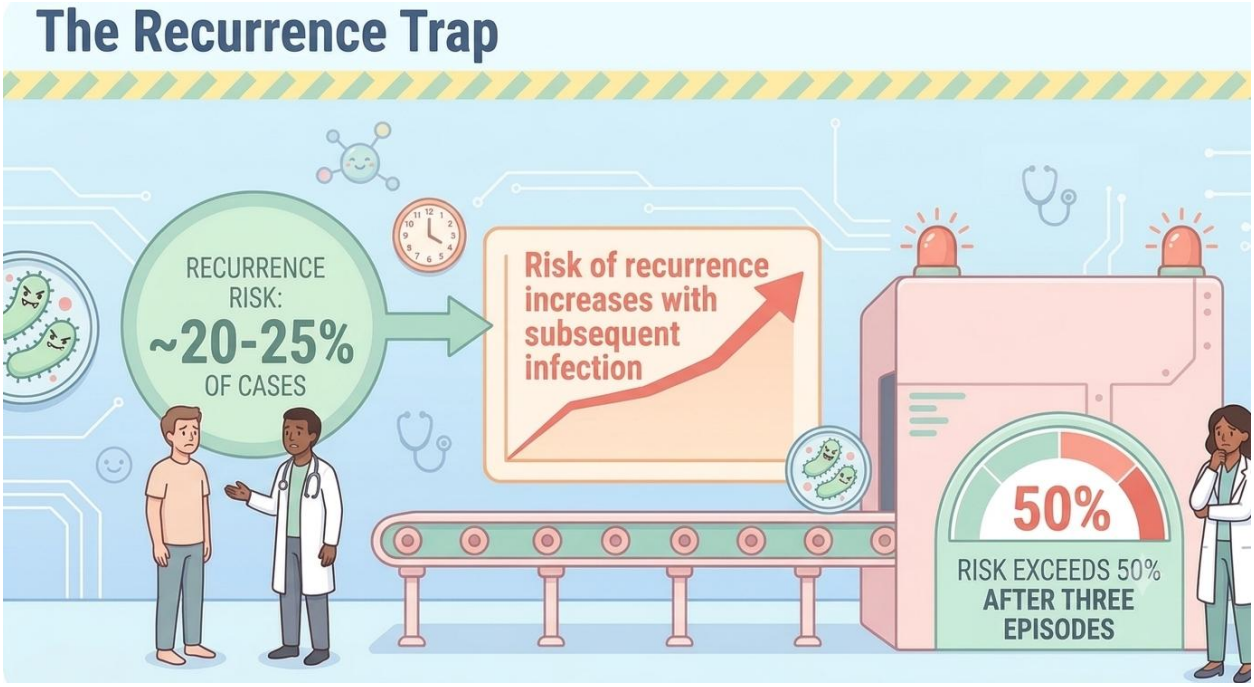
- Gut microbiome diversity is reduced with each additional antibiotic course.
- Disruptions to the abundance of gut species are not temporary; they can be detected **4 to 8 years after a single course of high-risk antibiotics** (such as clindamycin and fluroquinolones).



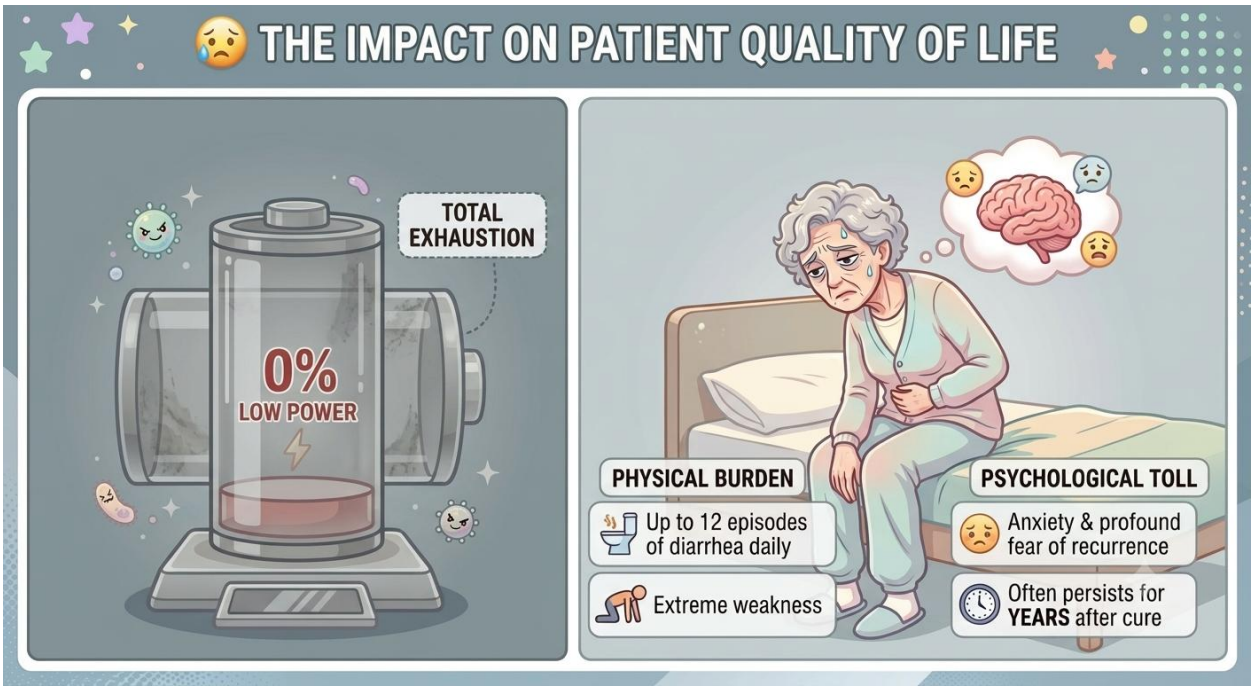




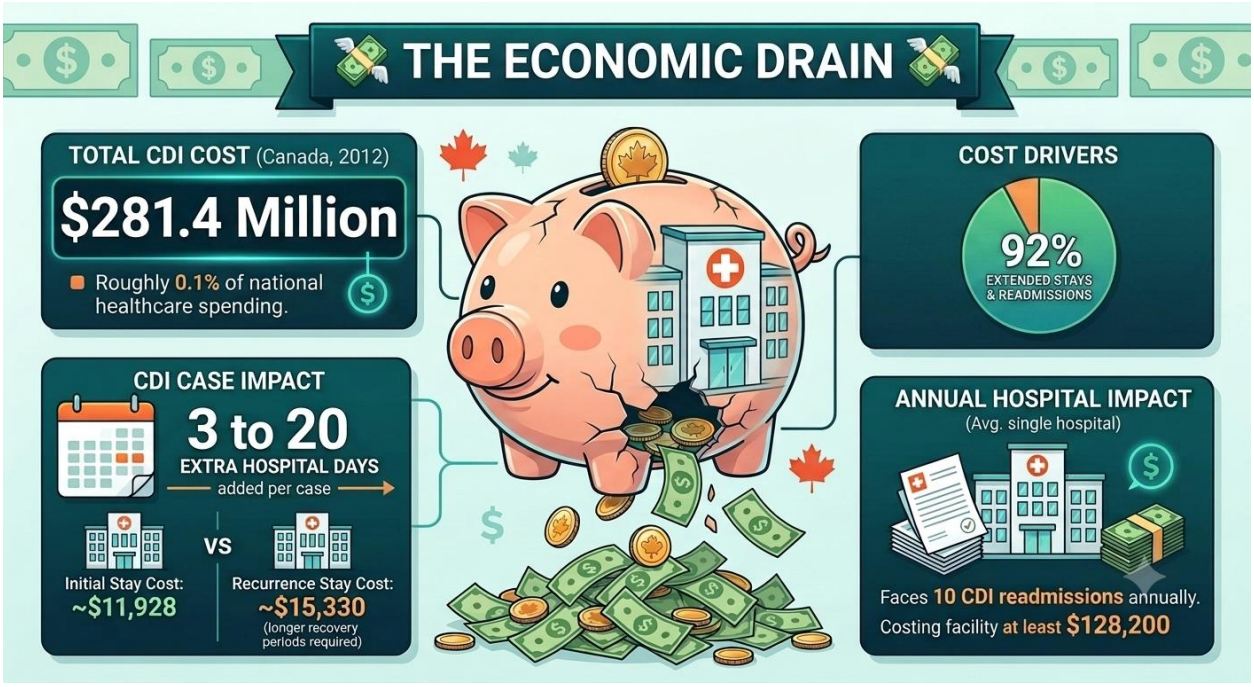
- Compared to patients receiving a single antibiotic, the risk of developing CDI is 2.5 times higher for those receiving two, 3.3 times higher for three or four, and 9.6 times higher for five or more. [2]



- CDI recurrences happen in 20–25% of cases. The risk of recurrence increases with each subsequent infection, exceeding 50% after three episodes. [3]



- Patients experience symptoms that significantly impact their quality of life. The psychological toll, including anxiety and a profound fear of recurrence, often persists for years. [4]



- Of the $281.4 million that CDI cost the Canadian healthcare system in 2012, 92% was driven directly by extended hospital stays and readmissions. This massive financial drain occurs because each infection would lead patients to remain hospitalized for an additional 3 to 20 days. [5-7]

References

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5. Levy AR, et al. Incidence and costs of Clostridium difficile infections in Canada. Open Forum Infect Dis 2015; 2:ofv121.
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