ASPIRES Treatment Guidelines: ***Clostridioides difficile Infection*** (CDI)

ANTIBIOTIC MANAGEMENT		DURATION
Mild or Moderate Disease ***(First episode)***	**First line**: Vancomycin 125 mg PO/NG QID **Second line:** Metronidazole 500 mg PO/NG TID (case-by-case basis or if cost of vancomycin prohibits use upon discharge) **If unable to administer orally or enterally:** Metronidazole 500 mg IV q8h	**10 days**
Severe Disease ***(First episode)*** *(WBC > 15 x 10^9/L OR SCr > 1.5x baseline or > 130 umol/L* OR pseudomembranous colitis)*	Vancomycin 125 mg PO/NG QID Consider ID consult	**10 days** **(14 days, if improved but incomplete resolution by 10 days)**
Fulminant Disease *(Hypotension, shock, ileus or toxic megacolon)*	Vancomycin 125 mg PO/NG QID **If complete ileus or critically ill:** Add Metronidazole 500 mg IV q8h **If unable to administer orally or enterally:** Consider adding Vancomycin 500 mg in 100 mL NS rectally q6h as a retention enema. Consider ID, General Surgery, and/or Critical Care consult	**10 days** **(14 days, if improved but incomplete resolution by 10 days)**
First Recurrence (*Within 8 weeks after treatment of an initial episode of CDI*)	Vancomycin 125 mg PO/NG QID x 10 days	**10 days**
	If first recurrence was severe and previously received vancomycin to treat primary episode, may consider a tapered regimen such as: Vancomycin 125 mg PO/NG BID x 7 days, then Vancomycin 125 mg PO/NG daily x 7 days, Vancomycin 125 mg PO/NG q2days x 4 doses, and Vancomycin 125 mg PO/NG q3days x 5 doses	**+/- taper**
Second or Multiple Recurrences	Vancomycin 125mg PO/NG QID x 14 days, then consider a tapered regimen such as: Vancomycin 125 mg PO/NG BID x 7 days, then Vancomycin 125 mg PO/NG daily x 7 days, Vancomycin 125 mg PO/NG q2days x 4 doses, and Vancomycin 125 mg PO/NG q3days x 5 doses Consider fecal microbiota transplantation (FMT) in multiple relapses especially after failed vancomycin taper. Consult ID and/or GI consult	**14 days** **+/- taper**

* if baseline SCr is unavailable

CONSIDERATIONS
• Discontinue or minimize frequency, number & duration of high-risk antibiotics if possible, especially clindamycin & quinolones • Discontinue antimotility or promotility agents • Discontinue proton pump inhibitors if possible • Discontinue bowel protocol • Asymptomatic patients with a positive *C. difficile* test (e.g. patients whose symptoms have spontaneously resolved without treatment after test was sent but before results were received) should not receive treatment • Failure to improve after 7 days of vancomycin strongly suggests an alternative etiology; consult ID and/or GI

References:
1. McDonald LC, Gerding DN, Johnson S, et al. Clinical Practice Guidelines for *Clostridium difficile* Infection in Adults and Children: 2017 Update by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA), *Clin Inf Dis*, Volume 66, Issue 7, 1 April 2018, Pages e1–e48, https://doi.org/10.1093/cid/cix1085
2. Kelly, CR, Fischer M, Allegretti, JR, et al. ACG Clinical Guidelines: Prevention, Diagnosis, and Treatment of *Clostridioides difficile* Infections. Am J Gastroenterol 116(6):p 1124-1147, June 2021. | DOI: 10.14309/ajg.0000000000001278
3. Nelson RL, Suda KJ, Evans CT. Antibiotic treatment for *Clostridium difficile*-associated diarrhoea in adults. Cochrane Database Syst Rev. 2017 Mar 3;3(3):CD004610. doi: 10.1002/14651858.CD004610.pub5. PMID: 28257555; PMCID: PMC6464548.
4. Rokas KE, Johnson JW, Beardsley JR, et al. The Addition of Intravenous Metronidazole to Oral Vancomycin is Associated With Improved Mortality in Critically Ill Patients With *Clostridium difficile* Infection. Clin Infect Dis. 2015 Sep 15;61(6):934-41. doi: 10.1093/cid/civ409. Epub 2015 May 29. PMID: 26024909.