Testing for Clostridium difficile is appropriate in patients:
- With unexplained and new-onset ≥ 3 unformed stools in 24 hours
- No administration of recent laxatives or stool softeners
- DO NOT use C. diff PCR for test of cure or on asymptomatic patients

If C. diff highly suspected or confirmed:
- Discontinue any unnecessary antibiotics immediately or as soon as possible
- Place patient in Enhanced Contact Precautions (wash hand with soap and water, alcohol based sanitizers alone are not adequate)
- Discontinue any non-required proton pump inhibitor
- Start treatment for C. diff infection (CDI) – see below treatment options
- Consider consultation of GI, ID, and/or General Surgery as appropriate in patients with severe disease (WBC >15 cells/µL, Scr >1.5 mg/dL)

**Treatment:**

**INITIAL EPISODE**

**Mild, moderate or severe**
Vancomycin 125 mg PO QID for 10 days*

**Fulminant episode with hypotension or shock, ileus, megacolon**
Vancomycin 500 mg PO QID by mouth or NG tube for 10 days*
If ileus, consider adding rectal instillation of vancomycin.
Metronidazole IV 500 mg every 8 hours should be administered together with oral or rectal vancomycin, particularly if ileus is present for 10 days*

*All randomized trials have compared 10-day treatment courses, but some patients may have delayed response to treatment and clinicians should consider extending treatment duration to 14 days or longer in those circumstances

**RECURRENT**

**First recurrence**
Use a prolonged tapered and pulsed vancomycin regimen:
125 mg QID for 10-14 days
125 mg BID for 7 days
125 mg daily for 7 days
125 mg QOD or Q3D for 2-8 week

**Second or subsequent**
Preferred: Vancomycin in a tapered and pulsed regimen OR
Consider FMT (requires GI/ID consult)*
Alternate: 1) Vancomycin 125 mg PO QID for 10 days followed by rifaximin 400 mg TID for 20 days OR
2) Fidaxomicin 200 mg PO daily for 10 days**

*Expert opinion states appropriate antibiotic treatment for at least 2 recurrences (ie, 3 CDI episodes) should be used prior to offering fecal microbiota transplantation
**Maybe preferred in patients at highest risk for recurrence: ulcerative colitis/inflammatory bowel disease, hematopoietic stem cell transplant and end stage renal disease

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