Assessment and Management of Clostridioides difficile Infections (CDI)

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care.

Note: Avoid use of unnecessary antibiotics. See Appendix A: Supportive Care Considerations.

**PRESENTATION**

Patient with 3 unformed stools in last 24 hours

- Has patient taken laxatives over the past 24-48 hours?
  - Yes: Stop laxative (if applicable) and reassess in 24 hours for clinical response prior to ordering *C. difficile* testing
  - No:
    - Has *C. difficile* DNA assay been ordered less than 7 days prior?
      - Yes: Seek alternate explanation for diarrhea
      - No:
        - Enter order for a single unformed stool specimen for *C. difficile* DNA assay
        - Place patient on contact isolation while awaiting results
        - Wash hands with soap and water before and after each patient contact

**ASSESSMENT**

- *C. difficile* DNA assay positive?
  - Yes: Continue contact isolation
  - No:
    - Have signs/symptoms resolved for 48 hours or are there alternative non-infectious causes of diarrheal symptoms identified?
      - Yes: Continue contact isolation
      - No:
        - Colonization is likely. Treatment usually not indicated; use clinical judgement in determining need for treatment.
          - Contact Infection Control to assess removal of isolation precautions

**INTERVENTION**

- Treatment for initial episode, non-fulminant disease (ADULT), see Page 2
- Treatment for initial episode, non-fulminant disease (PEDIATRIC), see Page 3
- Treatment for fulminant disease any episode (ADULT and PEDIATRIC), see Page 4
- Treatment for recurrent non-fulminant disease (ADULT), see Page 5
- Treatment for recurrent non-fulminant disease (PEDIATRIC), see Page 6

ELISA = enzyme-linked immunosorbent assay
EIA = enzyme immunoassay

1. Consider CDI in the setting of unexplained ileus
2. Consider other therapies/treatments that contribute to diarrhea before testing for *C. difficile*, such as tube feeding, chemotherapy and oral contrast
3. Bristol score of 6 or higher, see Appendix B for Bristol Chart
4. Reflective ELISA for *C. difficile* toxins A and B will be performed on all positive DNA assays. Use clinical judgement in interpreting significance of DNA positive, ELISA negative results.
5. Do not retest within 7 days, regardless of result
6. Criteria for fulminant disease include any of the following
   - Admission to the ICU
   - Toxic megacolon
   - Unable to take oral medications
   - Ileus
   - Hypotension
   - Septic shock
   - Peritonitis
   - Perforation

7. Infection Control (IC): Phone: (713) 792-3655 | Email: INFECTIONCONTROL@mdanderson.org

Copyright 2022 The University of Texas MD Anderson Cancer Center

Approved by the Executive Committee of the Medical Staff on 08/16/2022
Assessment and Management of Clostridioides difficile Infections (CDI)

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care.

Note: Avoid use of unnecessary antibiotics. See Appendix A: Supportive Care Considerations.

DISEASE SEVERITY (ADULT)  TREATMENT  REASSESSMENT

Initial episode, non-fulminant disease (ADULT)

- Fidaxomicin\(^1\,\,2\) 200 mg PO twice daily for 10-14 days or
- Vancomycin 125 mg oral solution\(^3\) PO every 6 hours for 10-14 days
- Carefully review concomitant antimicrobials and stop any that are not absolutely necessary

Reassess symptoms after 72 hours

Improvement?\(^4\)

- Complete course of therapy
- Use bezlotoxumab\(^5\) if institutional criteria met

Yes

No

Consult Infectious Diseases and Gastroenterology
For treatment failures at three days, consider transitioning to vancomycin (if previously on fidaxomicin)

Note: Metronidazole is no longer recommended for treatment of uncomplicated CDI except as an IV adjuvant for fulminant disease or if above agents are not available

\(^1\) Fidaxomicin is preferred over vancomycin for sustained clinical response (fewer recurrences). Consider fidaxomicin if patient is on concomitant systemic antibiotics

\(^2\) As of April 2022, only the tablet dosage form is available at the inpatient MDACC Pharmacy Formulary. Upon discharge, if fidaxomicin is unobtainable, it is reasonable to complete therapy with vancomycin PO.

\(^3\) May substitute with capsules if oral solution not available

\(^4\) Improvement is defined as a decrease in the number of unformed stools by 50% with hemodynamic stability

\(^5\) Refer to Appendix C for institutional use criteria
Assessment and Management of Clostridioides difficile Infections (CDI)

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care.

Note: Avoid use of unnecessary antibiotics. See Appendix A: Supportive Care Considerations.

DISEASE SEVERITY (PEDIATRIC)

- Initial episode, non-severe:
  - Treatment:
    - Vancomycin 40 mg/kg/day oral solution PO divided every 6 hours for 10-14 days (maximum dose of 2 g/day) or
    - Metronidazole 30 mg/kg/day PO divided every 6 hours for 10-14 days (maximum dose of 2 g/day)
    - Carefully review concomitant antimicrobials and stop any that are not absolutely necessary

- Initial episode, severe disease:
  - Criteria for severe disease:
    - Presence of visualized pseudomembranous colitis on endoscopy, able to take oral medications and/or
    - Any two of the following:
      - WBC > 15 K/microliter or ANC < 0.5 K/microliter
      - Serum creatinine (Scr)
        - Age < 2 years: Scr > 0.5 mg/dL
        - Age 2-8 years: Scr > 0.7 mg/dL
        - Age 9-18 years: Scr > 0.9 mg/dL
      - Albumin < 2.5 g/dL
      - GI graft versus host disease (GVHD)
      - Fever > 38.3°C
      - Abdominal cramping/pain
      - CT finding with colonic thickening, ascites, or pneumatosis
      - Diarrhea > 10 episodes per day
      - Concomitant chemotherapy or immunosuppression (including corticosteroids)

  - Treatment:
    - Vancomycin 40 mg/kg/day oral solution PO divided every 6 hours for 10-14 days (maximum dose of 2 g/day)
    - Carefully review concomitant antimicrobials and stop any that are not absolutely necessary

  - Reassessment:
    - Reassess symptoms after 72 hours
    - Improvement?
      - Yes
        - Complete course of therapy
      - No
        - Consult Infectious Diseases and Gastroenterology
        - For treatment failures at three days, consider transitioning to vancomycin (if previously on metronidazole)

  1 Non-severe disease: does not meet criteria for severe or fulminant disease
  2 May substitute with capsules if oral solution not available
  3 For both non-severe or severe: number of unformed stools decreased by 50% with hemodynamic stability

Copyright 2022 The University of Texas MD Anderson Cancer Center

Approved by the Executive Committee of the Medical Staff on 08/16/2022
Assessment and Management of Clostridioides difficile Infections (CDI)

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care.

Note: Avoid use of unnecessary antibiotics. See Appendix A: Supportive Care Considerations.

DISEASE SEVERITY
(ADULT & PEDIATRIC)

Treatment for fulminant disease1 any episode
(ADULT and PEDIATRIC)2

TREATMENT

- Choose one of the following:
  - Fidaxomicin3,4 200 mg PO/via NGT every 12 hours and metronidazole 500 mg IV every 8 hours or
  - Vancomycin 500 mg oral solution5 PO or via NGT every 6 hours and metronidazole6 500 mg IV every 8 hours
- Consider use of vancomycin retention enema [500 mg in 100 mL normal saline (NS) per rectum every 6 hours] if patient not neutropenic
- Consider Gastroenterology consultation for fecal microbiota transplant (FMT)7

- Vancomycin 40 mg/kg/day oral solution4 PO divided every 6 hours (maximum dose of 2 g/day) and metronidazole 30 mg/kg/day IV divided every 8 hours (maximum dose of 2 g/day)
- Consider use of vancomycin retention enema per rectum every 6 hours if patient not neutropenic
  - Age 1-3 years: 250 mg in 50 mL NS
  - Age 4-9 years: 375 mg in 75 mL NS
  - Age ≥ 10 years: 500 mg in 100 mL NS

REASSESSMENT

- Continue treatment for 10-14 days of therapy
- Reassess appropriateness of therapy continuously based on the patient’s clinical status
- Obtain Infectious Diseases and Gastroenterology consultations for possible FMT7

1 Criteria for fulminant disease include any of the following
- Admission to the ICU
- Toxic megacolon
- Septic shock
- Unable to take oral medications
- Hypotension
- Ileus
- Peritonitis
- Perforation

2 Consider consulting Surgery, Infectious Diseases, and Gastroenterology

3 Fidaxomicin is preferred over vancomycin for sustained clinical response (fewer recurrences)

4 As of April 2022, only the tablet dosage form is available at the inpatient MDACC Pharmacy Formulary. Upon discharge, if fidaxomicin is unobtainable, it is reasonable to complete therapy with vancomycin PO.

5 May substitute with capsules if oral solution not available

6 Metronidazole is no longer recommended for treatment of uncomplicated CDI except as an IV adjuvant for fulminant disease or if above agents are not available

7 Refer to Appendix D for fecal microbiota transplant indications

Copyright 2022 The University of Texas MD Anderson Cancer Center

Approved by the Executive Committee of the Medical Staff on 08/16/2022
Assessment and Management of Clostridioides difficile Infections (CDI)

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care.

Note: Avoid use of unnecessary antibiotics. See Appendix A: Supportive Care Considerations.

Recurrence 1 (Adult)

Treatment for recurrent non-fulminant disease (Adult):
Diarrea due to CDI (patient must have completed 10-14 days of effective therapy and have no symptoms for 48 hours after treatment has ended)

First recurrence

Second and subsequent recurrences

See Page 7

TREATMENT

- If metronidazole was used for the initial episode: Vancomycin 125 mg oral solution 2 PO every 6 hours for 10-14 days
- If vancomycin or metronidazole was used for the initial episode:
  - Fidaxomicin 3 200 mg PO twice daily for 10-14 days
  - If vancomycin or fidaxomicin was used for the initial episode: Vancomycin tapering/pulse treatment
    - 125 mg oral solution 2 PO every 6 hours for 14 days, then every 12 hours for 7 days, then once daily for 7 days, then every other day for 4 doses, then every third day for 5 doses, then off
    - Some patients may require chronic suppression thereafter
- Bezlotoxumab:
  - For all regimens, use bezlotoxumab 5 if institutional criteria are met and not previously administered

Reassess symptoms after 72 hours

Improvement?

Yes

Consider fecal microbiota transplant (FMT) 7,8 if first two episodes were associated with hospitalization or significant morbidity

Improvement?

No

Consider Infectious Diseases and Gastroenterology consultations for additional work up and possible FMT 7,8

1 Refer to Appendix E for prevention considerations
2 May substitute with capsules if oral solution not available
3 Fidaxomicin is preferred over vancomycin for sustained clinical response (fewer recurrences)
4 As of April 2022, only the tablet dosage form is available at the inpatient MDACC Pharmacy Formulary. Upon discharge, if fidaxomicin is unobtainable, it is reasonable to complete therapy with vancomycin PO.
5 Refer to Appendix C for institutional use criteria
6 Improvement is defined as a decrease in the number of unformed stools by 50% with hemodynamic stability
7 Refer to Appendix D for fecal microbiota transplant indications
8 Refer to Infectious Disease Clinic at (713) 792-2340 or Gastroenterology at (713) 794-5073

Copyright 2022 The University of Texas MD Anderson Cancer Center

Department of Clinical Effectiveness V4
Approved by the Executive Committee of the Medical Staff on 08/16/2022
Assessment and Management of *Clostridioides difficile* Infections (CDI)

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care.

**Note:** Avoid use of unnecessary antibiotics. See Appendix A: Supportive Care Considerations.

### RECURRENCE¹ (PEDIATRIC)

<table>
<thead>
<tr>
<th>Treatment for recurrent non-fulminant disease (PEDIATRIC)</th>
<th>TREATMENT</th>
</tr>
</thead>
</table>
| First recurrence                                          | ¹ If metronidazole or fidaxomicin was used for the initial episode:  
  Vancomycin 40 mg/kg/day oral solution² PO divided every 6 hours for 10-14 days  
  If vancomycin was used for the initial episode: Fidaxomicin³. Weight-based dosing for infants age ≥ 6 months to < 18 years: 16 mg/kg/dose PO twice daily for 10-14 days, maximum 200 mg/dose  
  Doses may be rounded as listed below:  
  - Weight 4 to < 7 kg: 80 mg PO twice daily  
  - Weight 7 to < 9 kg: 120 mg PO twice daily  
  - Weight 9 to < 12.5 kg: 160 mg PO twice daily  
  - Weight ≥ 12.5 kg: 200 mg PO twice daily  
  ² If vancomycin or fidaxomicin was used for the initial episode: Vancomycin tapering/pulse treatment (for age < 18 years):  
  - 10 mg/kg/dose oral solution⁴ PO every 6 hours for 14 days, then every 12 hours for 7 days, then once daily for 7 days, then every other day for 4 doses, then every third day for 5 doses, then off  |
| Second and subsequent recurrences                        | See Page 7 |

<table>
<thead>
<tr>
<th>Improvement?⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement⁴</td>
</tr>
<tr>
<td>Reassess symptoms after 72 hours</td>
</tr>
</tbody>
</table>

### Consider fecal microbiota transplant (FMT)⁵,⁶ if first two episodes were associated with hospitalization or significant morbidity

1 Refer to Appendix E for prevention considerations  
2 May substitute with capsules if oral solution not available  
3 As of April 2022, only the tablet dosage form is available at the inpatient MDACC Pharmacy Formulary. Upon discharge, if fidaxomicin is unobtainable, it is reasonable to complete therapy with vancomycin PO.  
4 Improvement is defined as a decrease in the number of unformed stools by 50% with hemodynamic stability  
5 Refer to Appendix D for fecal microbiota transplant indications  
6 Refer to Infectious Disease Clinic at (713) 792-2340, Pediatric Infectious Disease at (713) 792-6610 or Gastroenterology at (713) 794-5073
Assessment and Management of Clostridioides difficile Infections (CDI)

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care.

Note: Avoid use of unnecessary antibiotics. See Appendix A: Supportive Care Considerations.

RECURRENT1 (ADULT & PEDIATRIC)

| Adult | Second and subsequent recurrences² |

- If vancomycin or metronidazole was used for the most recent episode:
  - Fidaxomicin: 200 mg PO twice daily for 10-14 days
  - If metronidazole was used for the most recent episode: Vancomycin 125 mg oral solution³ PO every 6 hours for 10-14 days
  - If solid tumor patient or not immunocompromised: Fidaxomicin: 200 mg PO twice daily for 5 days, followed by once every other day for 20 days
  - Vancomycin course followed by tapering/pulse treatment:
    - 125 mg oral solution⁴ PO every 6 hours for 14 days, then every 12 hours for 7 days, then once daily for 7 days, then every other day for 4 doses, then every third day for 10-14 doses, then off
  - For all regimens, use bezlotoxumab⁵ if institutional criteria met and not previously administered
  - Consider FMT⁶,⁷

- If vancomycin was used for the most recent episode:
  - Fidaxomicin: weight-based dosing for infants age ≥ 6 months to < 18 years: 16 mg/kg/dose PO twice daily for 10-14 days, maximum 200 mg/dose. Doses may be rounded as listed below:
    - Weight 4 to < 7 kg: 80 mg PO twice daily
    - Weight 7 to < 9 kg: 120 mg PO twice daily
    - Weight 9 to < 12.5 kg: 160 mg PO twice daily
    - Weight ≥ 12.5 kg: 200 mg twice PO daily
  - If vancomycin or fidaxomicin was used for the most recent episode:
    - Vancomycin tapering/pulse treatment (for age < 18 years):
      - 10 mg/kg/dose oral solution⁷ PO every 6 hours for 14 days, then every 12 hours for 7 days, then once daily for 7 days, then every other day for 4 doses, then every third day for 10-14 doses, then off

TREATMENT

- If vancomycin or fidaxomicin was used for the most recent episode:
  - Consider Infectious Disease consultation for recurrent CDI
  - Vancomycin is preferred over fidaxomicin for sustained clinical response (fewer recurrences).
  - As of April 2022, only the tablet dosage form is available at the inpatient MDACC Pharmacy Formulary. Upon discharge, if fidaxomicin is unobtainable, it is reasonable to complete therapy with vancomycin PO.
  - Consider extended therapy of fidaxomicin for patients on concomitant systemic antibiotics or age > 60 years
  - May substitute with capsules if oral solution not available
  - Duration depends on risk of recurrence (e.g., if receiving additional antibiotics, bridge to FMT, awaiting stem cell engraftment, etc.)

- If vancomycin was used for the most recent episode:
  - Fidaxomicin: refer to Appendix E for prevention considerations

- If metronidazole was used for the most recent episode:
  - Duration depends on risk of recurrence (e.g., if receiving additional antibiotics, bridge to FMT, awaiting stem cell engraftment, etc.)

- If vancomycin or fidaxomicin was used for the most recent episode:
  - Consider continuing prophylaxis in selected patients and those awaiting FMT (consult Gastroenterology and Infectious Diseases)

1 Refer to Appendix E for prevention considerations
2 Consider Infectious Disease consultation for recurrent CDI
3 Fidaxomicin is preferred over vancomycin for sustained clinical response (fewer recurrences).
4 As of April 2022, only the tablet dosage form is available at the inpatient MDACC Pharmacy Formulary. Upon discharge, if fidaxomicin is unobtainable, it is reasonable to complete therapy with vancomycin PO.
5 Consider extended therapy of fidaxomicin for patients on concomitant systemic antibiotics or age > 60 years
6 May substitute with capsules if oral solution not available
7 Duration depends on risk of recurrence (e.g., if receiving additional antibiotics, bridge to FMT, awaiting stem cell engraftment, etc.)
8 Refer to Appendix C for institutional use criteria
9 Refer to Appendix D for fecal microbiota transplant indications
10 Refer to Infectious Disease Clinic at (713) 792-2340 or Pediatric Infectious Disease at (713) 792-6610 or Gastroenterology at (713) 794-5073
11 Improvement is defined as a decrease in the number of unformed stools by 50% with hemodynamic stability
12 Consider continuing prophylaxis in selected patients and those awaiting FMT (consult Gastroenterology and Infectious Diseases)
APPENDIX B

Clindamycin and fluoroquinolones are associated with the highest risk of CDI. Whenever possible, avoid these agents and all other unnecessary antibiotics, particularly those with anaerobic activity such as ampicillin/sulbactam, piperacillin/tazobactam, and carbapenems.

Supportive care with hydration, avoidance of anti-motility agents, opiates and bile salts binding agents.

Probiotics are not recommended in cancer patients with CDI. There are no randomized, peer reviewed studies to support the use of probiotics for the prevention or treatment of CDI in cancer patients. Cases of bacteremia (Lactobacillus) and fungemia (Saccharomyces) have been described in immunosuppressed patients receiving probiotics.

For patients with a high index of suspicion for severe CDI and negative diagnostic studies, and if not contraindicated, consider diagnostic colonoscopy to examine for pseudomembrane formation. The decision for therapy in these patients is left at the discretion of the treating physician, consider Infectious Diseases consultation.

APPENDIX A: Supportive Care Considerations
APPENDIX C: Institutional Bezlotoxumab Use Criteria (Adults Only)

- Restricted to outpatient use only, with an exception for inpatients with an extended hospitalization that would not allow outpatient administration during concomitant antibacterial treatment for *C. difficile* infection (anti-CDI therapy)
- Must have a positive stool *C. difficile* nucleic acid amplification test and a positive toxin by enzyme-linked immunosorbent assay (ELISA)
- Must be receiving concomitant anti-CDI therapy (e.g., vancomycin, fidaxomicin, metronidazole)
- Presence of at least one of the following risk factors for recurrent CDI:
  - Age ≥ 60 years
  - At least one prior episode of CDI
  - Compromised immunity: currently receiving immunosuppressants, neutropenia (e.g., ANC < 0.5 K/microliter), and/or lymphopenia (e.g., ALC < 0.2 K/microliter)
  - Clinically severe CDI
    - Presence of visualized pseudomembranous colitis on endoscopy, able to take oral medications and/or
    - Any two of the following:
      - Age > 60 years
      - WBC > 15 K/microliter or ANC < 0.5 K/microliter
      - Serum creatinine (SCR) > 1.5 mg/dL
      - Albumin < 2.5 g/dL
      - GI graft versus host disease (GVHD)
      - Fever > 38.3°C
      - Abdominal cramping/pain
      - CT finding with colonic thickening, ascites, or pneumatosis
      - Diarrhea > 10 episodes per day
      - Concomitant chemotherapy or immunosuppression (including corticosteroids)
- Patient expected to continue non-CDI antibiotics ≥ 3 days beyond end of anti-CDI therapy
APPENDIX E: Prevention Considerations

- Prolonged courses of perioperative antibiotic prophylaxis beyond a single dose is discouraged except in selected circumstances
  
  - The use of prophylactic antibiotics in patients receiving chemotherapy is discouraged. Exceptions are in patients with neutropenia associated with leukemia and HSCT
  
  - Continued use of antibiotics during therapy for *Clostridioides difficile* increases risk of failure and recurrence. Discontinue concomitant antibiotics as soon as possible following diagnosis of *C. difficile*
  
  - Empiric therapy while awaiting diagnostic testing results is discouraged except in cases of suspected severe CDI (*e.g.*, toxic megacolon, ileus, severe colitis) or when a pseudomembrane is identified on endoscopy.
  
  - Given the high rates of asymptomatic colonization (3-8%), the detection of *C. difficile* nucleic acid test (NAT) by itself is not sufficient to justify specific therapy unless there is a high index of clinical suspicion (*e.g.*, clinically significant diarrhea and no confirmed alternative causes).

- Follow infection control measures including:
  
  - Initiate contact isolation for suspected CDI while awaiting test results
  
  - Wash hands with soap and water prior to entering and exiting the room. Wear a gown and gloves. The use of hand sanitizer is insufficient to kill *C. difficile* spores.
  
  - Clean shared patient care items with a hospital approved bleach product, according to manufacturer’s instructions
  
  - Do not re-test for CDI for the sole purpose of removing isolation. Patients who are no longer passing unformed stools will be re-evaluated by an infection preventionist prior to discontinuation of isolation. Only an infection preventionist has the authority to remove patients from isolation.

- Preferably delay chemotherapy until CDI treatment has been completed and diarrhea has resolved

- Consider delaying radiation therapy until GI symptoms have resolved

---

**APPENDIX D: Fecal Microbiota Transplant Indications**

- Recurrent or relapsing CDI (all CDI must be diagnosed by positive stool test for *C. difficile*):
  
  - Three or more episodes of mild-to-moderate CDI and failures of a 6-8 week taper with vancomycin with or without an alternative antibiotic (*e.g.*, rifaximin, nitazoxanide, or fidaxomicin)
  
  - At least two episodes of CDI resulting in hospitalization and associated with significant morbidity

- CDI not responding to standard therapy (vancomycin or fidaxomicin) for at least a week

- Severe (even fulminant CDI) with no response to standard therapy after 48 hours

- Ileus and in patients in whom vancomycin enemas are contraindicated or could cause bowel perforation

- Without severe neutropenia (ANC > 0.5 K/microliter, preferably >1 K/microliter)
Assessment and Management of Clostridioides difficile Infections (CDI)

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care.

SUGGESTED READINGS


MD Anderson Institutional Policy #CLN0432 - Isolation Policy


Assessment and Management of Clostridioides difficile Infections (CDI)

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care.

DEVELOPMENT CREDITS

This practice consensus statement algorithm is based on majority opinion of the Infection Control Infectious Disease, and Pediatrics experts at the University of Texas MD Anderson Cancer Center for the patient population. These experts included:

Core Development Team Leads
Antimicrobial Stewardship Team
Sherry Cantu, MPH, CIC (Infection Control)
Pablo C. Okhuysen, MD, FACP, FIDSA (Infectious Diseases, Infection Control and Employee Health)

Workgroup Members
Jose Cortes, MD (Pediatrics)
Olga N. Fleckenstein, BS*
Suzanne Gettys, PharmD (Pharmacy Clinical Programs)
Linda Graviss, MT, ASCP, CIC (Infection Control)
Yinghong Wang, MD (Gastroenterology Hepatology & Nutrition)
Milena Zhang, PharmD*

* Clinical Effectiveness Development Team