Patient has diarrhea of unknown etiology where an infectious etiology is suspected

Place contact isolation sign on door
If *C. difficile* is suspected or confirmed:
- hand hygiene should be performed using soap and water only
- add orange “soap and water only” sign to door

Clinical settings to test for *C. difficile*:
1) Diarrhea (or severe ileus) associated with antibiotic use or hospitalization (current or within 3 months) with any of the following signs or symptoms:
   a) Fever
   b) Leukocytosis
   c) Abdominal cramping
2) Hospitalized patient with new diarrhea in setting of *C. difficile* outbreak

Positive test
Positive *C. difficile* antigen AND toxin (continue contact isolation)

Stop inciting antibiotics if possible OR avoid antibiotics commonly associated with *C. difficile* infection (ceftriaxone, levofloxacin, ampicillin, clindamycin)

Indeterminate test
Positive *C. difficile* antigen and negative toxin (continue contact isolation)

Indeterminate test may reflect:
1) Colonization with a non-toxin-producing strain (most common, treatment not indicated)
2) *C. difficile* infection present but insufficient level of toxin to be detected (less common)

Negative test
Negative antigen AND toxin

Discontinue isolation when diarrhea controlled

Risk stratify to determine appropriate therapy for *C. difficile*

Mild to moderate disease
- More than 3 stools per 24hrs and
- No features of severe disease

Oral metronidazole
500 mg TID for 10–14 days

No improvement or clinical deterioration

Infectious Diseases and General Surgery consultations

Severe disease
- ICU admission OR any 2 of the following:
  o Age >60 years
  o Temperature >38.3 C or 101 F
  o Albumin level <2.5 mg/dL
  o WBC >15,000 cell/mm³

Oral vancomycin 125mg 4x/day for 10-14 days

No improvement or clinical deterioration

Oral vancomycin 500mg 4x/day with or without IV metronidazole 500mg Q8H

If ileus, add vancomycin 500mg retention enema 4x/day

Critical illness
- Severe sepsis or shock
- Severe ileus
- Peritoneal signs
- Pseudomembranous colitis
- Toxic megacolon

*Obtain immediate General Surgery and Infectious Diseases consultations

• *C. difficile* PCR reflexively performed (reported in “Microbiology sendouts”)
  • Consider empiric therapy (below) and retesting if high clinical suspicion for infection

This is intended as a guide for evidence-based decision-making and is not intended to replace clinical judgment. Assess for antibiotic allergies and use alternative agents as appropriate.