

ANMC Pediatric *Clostridium (Clostridioides) difficile* Infection (CDI) Treatment Guideline

Special Pediatric Considerations

Infants and toddlers have high rates of non-pathologic colonization with *Clostridium difficile*. **Routine testing is not recommended in children <2 years old.**

< 1 year of age:	1-2 year(s) of age:	≥ 2 years of age:
<ul style="list-style-type: none"> Routine testing is not recommended due to high colonization rates (colonization rates can exceed 40%) Test if infant has evidence of pseudomembranous colitis or toxic megacolon Positive test result indicates <i>possible</i> CDI → continue to seek alternate diagnoses 	<ul style="list-style-type: none"> Routine testing is not recommended due to high colonization rates Excluded other causes of infectious or non-infectious diarrhea before testing for CDI Positive test result indicates <i>possible</i> CDI → continue to seek alternate diagnoses 	<ul style="list-style-type: none"> Testing is recommended for patients with prolonged or worsening diarrhea AND risk factors or relevant exposures

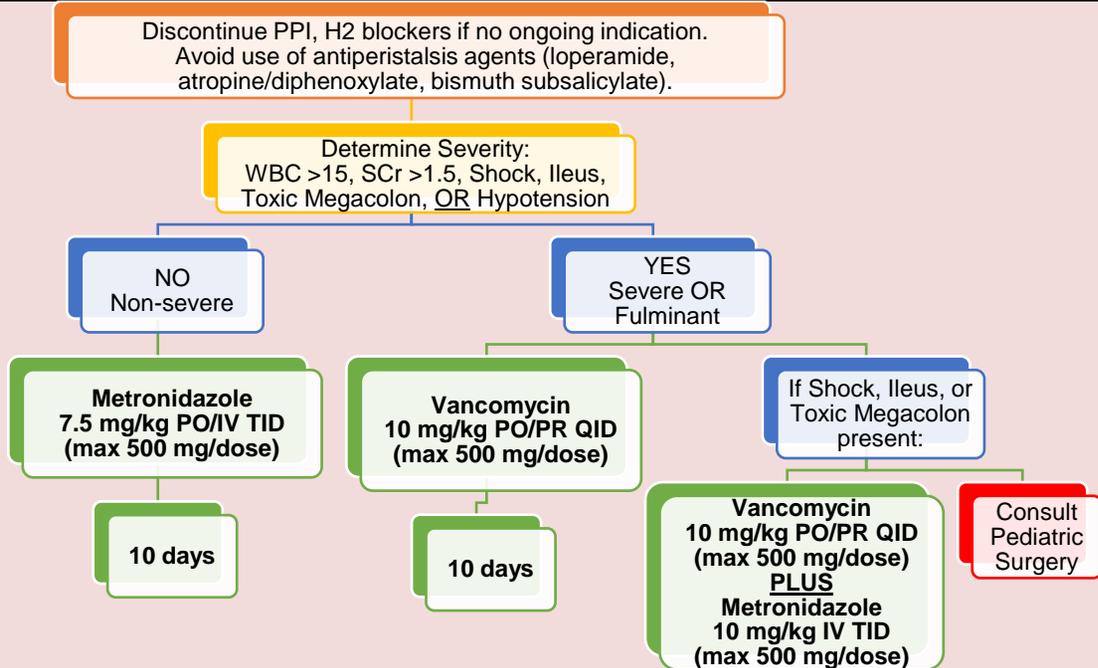
Risk Factors

<ul style="list-style-type: none"> Recent hospitalization or known contact in the community Antibiotics in previous 90 days PPI/H2 Blocker use (risk of causing <i>C. difficile</i>: PPI>H2 Blocker) Immunocompromised (including malignancy, solid organ transplant, IBD) Renal insufficiency 	<ul style="list-style-type: none"> Hirschprung disease or other underlying bowel disease History of GI tract surgery Gastrostomy or jejunostomy tube; prolonged NG tube insertion Repeated enemas Diaper use in older children
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Clinical Findings

Signs & Symptoms	Confounding Factors – Testing Discouraged	Laboratory Findings
<ul style="list-style-type: none"> Abdominal pain/tenderness ≥ 3 watery/unformed stools in a 24 hour period Mucous and/or blood in stool Fever Decreased albumin Elevated WBC, SCR 	<ul style="list-style-type: none"> <2 years old (see above) Laxative or enteral feeding use within previous 24-48 hours 	<ul style="list-style-type: none"> Positive <i>Clostridium difficile</i> DNA amplification test (2 hour turnaround for results) Test of cure should not be performed. Repeat tests sent within 7 days will be rejected by the microbiology department

Antibiotic Selection



First Recurrence (Non-Severe)

Metronidazole 7.5 mg/kg PO/IV TID (max 500 mg/dose) OR Vancomycin 10 mg/kg PO QID (max 125 mg/dose) x14 days

Second or Greater Recurrence

Vancomycin 10 mg/kg PO QID (max 125 mg/dose) x14 days, followed by 4 week taper:

- Vancomycin 10 mg/kg PO BID (max 125 mg/dose) x7 days, then
- Vancomycin 10 mg/kg PO QD (max 125 mg/dose) x7 days, then
- Vancomycin 10 mg/kg PO QOD (max 125 mg/dose) x7 days, then
- Vancomycin 10 mg/kg PO q72hr (max 125 mg/dose) x7 days

Consider for referral for fecal microbiota transplantation after multiple recurrences with standard antibiotic treatment and discussion with pediatric ID and pediatric gastroenterology.

Notes

- If ongoing therapy with *C. difficile* predisposing antimicrobial regimen, upon completion of 10 days of QID dosing continue enteral vancomycin BID until completion of therapy
 - o *C. difficile* predisposing antimicrobial therapy should be narrowed when possible and treatment should be for the shortest duration clinically necessary
- Discontinue PPIs, H2 Blockers, if no ongoing indication (Exclusion: GI bleed, *H. pylori* infection, gastric/duodenal ulcer, erosive esophagitis, chronic NSAID/steroid use)