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:
- 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 *possible* CDI → continue to seek alternate diagnoses

1-2 year(s) of age:
- 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 *possible* CDI → continue to seek alternate diagnoses

≥ 2 years of age:
- Testing is recommended for patients with prolonged or worsening diarrhea AND risk factors or relevant exposures

Risk Factors

- Recent hospitalization or known contact in the community
- Antibiotics in previous 90 days
- PPI/H2 Blocker use (risk of causing C.difficile: PPI>H2 Blocker)
- Immunocompromised (including malignancy, solid organ transplant, IBD)
- Renal insufficiency
- 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

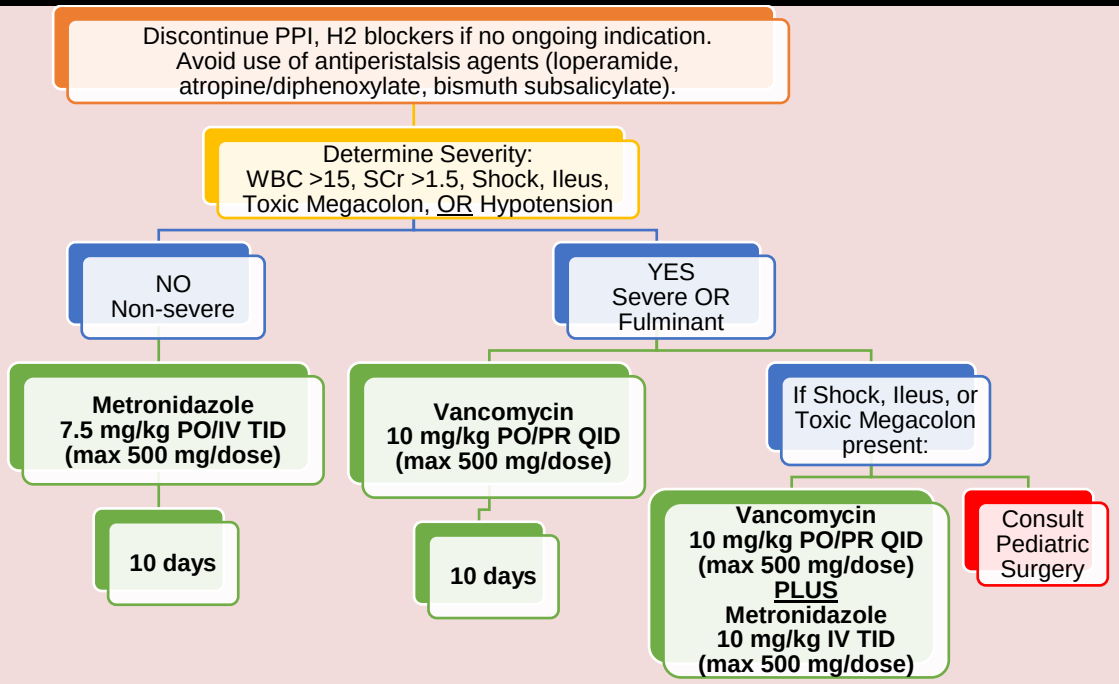
Clinical Findings

Signs & Symptoms
- Abdominal pain/tenderness
- ≥ 3 watery/unformed stools in a 24 hour period
- Mucous and/or blood in stool
- Fever
- Decreased albumin
- Elevated WBC, SCr

Confounding Factors – Testing Discouraged
- <2 years old (see above)
- Laxative or enteral feeding use within previous 24-48 hours

Laboratory Findings
- Positive *Clostridium difficile* 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
  - *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)

ANMC Antimicrobial Stewardship Program Approved April 2018

Clinical Practice Guidelines for *Clostridium difficile* Infection. *CID*. 2018; AAP Policy Statement: *Clostridium difficile* Infection in Infants and Children. Pediatrics. 2013: 131 (1): 196-200.