This clinical guideline has been developed to ensure appropriate diagnosis, evaluation, and treatment for pediatric patients presenting with *C. difficile* associated diarrhea/disease. Please direct any questions to Jenny Jubulis, MD, at 662-5522.

The **diagnosis** of *C. difficile* disease **requires** positive stool testing for toxigenic *C. difficile* or its toxins. Discontinuing or shortening the course of non-*C. difficile* antibiotics (especially clindamycin, cephalosporins, and/or fluoroquinolones) is strongly recommended.

### Classification of *C. difficile* Disease:

**Mild/Moderate Disease**: 3 or more unformed stools in 24 hours

**Severe Disease**: 3 or more unformed stools in 24 hours

AND

Peripheral White Blood Cell Count over 15,000/uL OR Creatinine > 50% of baseline

**Severe, Complicated Disease**: 3 or more unformed stools in 24 hours

AND

Peripheral White Blood Cell Count over 15,000/uL OR Creatinine > 50% of baseline

AND, at least one of the following:

- Hypotension
- Toxic Megacolon
- Ileus
- Need for a colectomy
- Clinical or radiographic evidence of bowel perforation
- CT evidence of pancolitis
- Critical care admission for illness related to *C. difficile* infection

### Treatment

| Initial episode of mild or moderate disease | Metronidazole PO 7.5 mg/kg/dose Q6 hours for 10-14 days (max 500 mg Q6 hours) |
| Initial episode of severe disease | Vancomycin PO 12.5 mg/kg/dose Q6 hours for 10-14 days (max dose 125 mg Q6 hours) |
| Initial episode of severe, complicated disease | Vancomycin PO + metronidazole IV-same doses as above If complete ileus, consider ID and GI consults for adding rectal installation of vancomycin. |
| First recurrence | Same therapy as for initial episode |
| Second recurrence | PO vancomycin in a tapered regimen: 12.5 mg/kg Q6 hours x 14 days (max 125 mg Q6 hours) 12.5 mg/kg QD x 7 days (max 125 mg QD) 12.5 mg/kg Qday x 7 days (max 125 mg Qday) 12.5 mg/kg every other day x 14 days (max 125 mg every other day) |

**Stool transplant remains experimental in this population**

### Patient/Family/Provider Education:

1. Encourage patients, families, and providers to clean bathrooms after each bowel movement, using bleach and disposable paper towels.
2. Use soap and water to wash hands. Alcohol-based hand sanitizers do not kill *C. difficile* spores.
3. Hospitalized patients with *C. difficile* associated diarrhea require enteric precautions.
4. At the conclusion of treatment for *C. difficile*, no test of cure is indicated.
The following therapies have no role in the treatment of *C. difficile* associated diarrhea and may be harmful to patients:

- Probiotics
- Binding agents (cholestyramine, colestipol)
- Antiperistaltic agents
- Proton-pump inhibitors
- Rifampin
- Rifaximin

The following therapies have no role in the prevention of *C. difficile* associated diarrhea, even in patients with a history of *C. difficile* infection/disease who are receiving antibiotics:

- Metronidazole
- Vancomycin

This clinical guideline has been developed by the Pediatric Antimicrobial Stewardship Program at Maine Medical Center and is based on the recommendations from the American Academy of Pediatrics, Red Book: 2012, Report of the Committee on Infectious Disease and the 2010 Clinical Practice Guidelines for *Clostridium difficile* in Adults, Infectious Disease Society of America.

Algorithms are not intended to replace providers’ clinical judgement or to establish a single protocol. Some clinical problems may not be adequately addressed in this guideline. As always, clinicians are urged to document management strategies. *Last revised September 2013, reviewed May 2014.*