Clinical Practice Guidelines for Clostridium difficile Infection in Adults and Children: 2017 Update by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA) | Clinical Infectious Diseases | Oxford Academic (oup.com)

DIAGNOSIS

VI. What is the preferred population for *C. difficile* testing, and should efforts be made to achieve this target?

Recommendation

1. Patients with unexplained and new-onset ≥3 unformed stools in 24 hours are the preferred target population for testing for CDI *(weak recommendation, very low quality of evidence).*

VII. What is the best-performing method (ie, in use positive and negative predictive value) for detecting patients at increased risk for clinically significant *C. difficile* infection in commonly submitted stool specimens?

Recommendation

1. Use a stool toxin test as part of a multistep algorithm (ie, glutamate dehydrogenase [GDH] plus toxin; GDH plus toxin, arbitrated by nucleic acid amplification test [NAAT]; or NAAT plus toxin) rather than a NAAT alone for all specimens received in the clinical laboratory when there are no preagreed institutional criteria for patient stool submission (Figure 2) *(weak recommendation, low quality of evidence).*

VIII. What is the most sensitive method of diagnosis of CDI in stool specimens from patients likely to have CDI based on clinical symptoms?

Recommendation

1. Use a NAAT alone or a multistep algorithm for testing (ie, GDH plus toxin; GDH plus toxin, arbitrated by NAAT; or NAAT plus toxin) rather than a toxin test alone when there are preagreed institutional criteria for patient stool submission (Figure 2) *(weak recommendation, low quality of evidence).*

IX. What is the role of repeat testing, if any? Are there asymptomatic patients in whom repeat testing should be allowed, including test of cure?

Recommendation

1. Do not perform repeat testing (within 7 days) during the same episode of diarrhea and do not test stool from asymptomatic patients, except for epidemiological studies *(strong recommendation, moderate quality of evidence).*

X. Does detection of fecal lactoferrin or another biologic marker improve the diagnosis of CDI over and above the detection of toxigenic *C. difficile* Can such a subset predict a more ill cohort?

Recommendation

1. There are insufficient data to recommend use of biologic markers as an adjunct to diagnosis *(no recommendation*).

XIII. Should private rooms and/or dedicated toilet facilities be used for isolated

patients with CDI?

Recommendations

1. Accommodate patients with CDI in a private room with a dedicated toilet to decrease transmission to other patients. If there is a limited number of private single rooms, prioritize patients with stool incontinence for placement in private rooms *(strong recommendation, moderate quality of evidence*).

2. If cohorting is required, it is recommended to cohort patients infected or colonized with the same organism(s)—that is, do not cohort patients with CDI who are discordant for other multidrug-resistant organisms such as methicillin-resistant *Staphylococcus aureus* or vancomycin-resistant *Enterococcus (strong recommendation, moderate quality of evidence*).

XIV. Should gloves and gowns be worn while caring for isolated CDI patients?

Recommendation

1. Healthcare personnel must use gloves *(strong recommendation, high quality of evidence*) and gowns *(strong recommendation, moderate quality of evidence*) on entry to a room of a patient with CDI and while caring for patients with CDI.

XV. When should isolation be implemented?

Recommendation

1. Patients with suspected CDI should be placed on preemptive contact precautions pending the *C. difficile* test results if test results cannot be obtained on the same day *(strong recommendation, moderate quality of evidence*).

XVI. How long should isolation be continued?

Recommendations

1. Continue contact precautions for at least 48 hours after diarrhea has resolved *(weak recommendation, low quality of evidence*).

2. Prolong contact precautions until discharge if CDI rates remain high despite implementation of standard infection control measures against CDI *(weak recommendation, low quality of evidence*).

XVII. What is the recommended hand hygiene method (assuming glove use) when caring for patients in isolation for CDI?

Recommendations

1. In routine or endemic settings, perform hand hygiene before and after contact of a patient with CDI and after removing gloves with either soap and water or an alcohol-based hand hygiene product *(strong recommendation, moderate quality of evidence*).

2. In CDI outbreaks or hyperendemic (sustained high rates) settings, perform hand hygiene with soap and water preferentially instead of alcohol-based hand hygiene products before and after caring for a patient with CDI given the increased efficacy of spore removal with soap and water *(weak recommendation, low quality of evidence).*

3. Handwashing with soap and water is preferred if there is direct contact with feces or an area where fecal contamination is likely (eg, the perineal region) *(good practice recommendation*).