BRINGING CLINICIANS TOGETHER TO DISCUSS CURRENT DRUG THERAPY

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INFECTIOUS DISEASES

You’ll see a shift in meds to treat Clostridium difficile in adults due to new guidelines from Infect Dis Soc of America (IDSA).

Metronidazole has been the standard for treating C. diff...with oral vancomycin often saved for severe or recurrent infections.

But about one in 4 patients relapse after a first C. diff episode.

Lean toward vancomycin for initial treatment and recurrences. A month after treatment, one more patient will have resolution of diarrhea for every 10 patients treated with vancomycin instead of metronidazole.

Treat an initial C. diff bout with oral vancomycin QID for 10 days.

But if diarrhea recurs, use an extended taper. For example, after the initial 10-day course, give vancomycin in BID for a week...daily for a week...then once every 2 to 3 days for up to 8 weeks.

Prescribe Firvanq oral vancomycin solution. It’s grape flavored and costs about $125 for 10 days...versus $600 for generic vancomycin caps.

It’s still okay to use metronidazole for mild infections, such as white count 15,000 or less and creatinine below 1.5 mg/dL...especially if cost of vancomycin is a barrier.

Metronidazole is TID and costs about $15 for 10 days. But repeat courses could lead to neurotoxicity...dizziness, ataxia, confusion, etc.

Save fidaxomicin (Dificid) for patients who relapse after vancomycin. Recurrence rates may be lower than vancomycin in some patients...but 10 days of BID fidaxomicin cost about $3,700.

Refer for fecal transplant when patients have 3 or more C. diff episodes...to restore a healthy GI flora.

Don’t discourage probiotics if patients want to try one...to prevent C. diff while taking an antibiotic, in combo with usual C. diff treatment, or to prevent recurrent C. diff. Suggest a product with Saccharomyces boulardii (Florastor, etc) or Lactobacillus species (Culturelle, etc).

To prevent C. diff, continue to limit antibiotics...especially clindamycin, quinolones, etc. Also stop unnecessary PPIs.

Don’t use a stool test to see if C. diff has cleared...patients may remain asymptomatic carriers after treatment.

Hear our PL Voices team discuss the latest updates with an author of the guidelines. And see our chart, Clostridium difficile in Adults, for more about risk factors, recurrent infections, etc.

(For more on this topic, see Clinical Resource #340417 at PrescribersLetter.com.)


See LEADER NOTES for answers to discussion questions.
DISCUSSION QUESTIONS

OVERVIEW OF CURRENT THERAPY

1. What are the new Clostridium difficile guidelines?

ANALYSIS OF NEW STUDY

2. What are the criteria for development or evaluation of practice guidelines?

3. Are the new guidelines for Clostridium difficile evidence-based? Is evidence linked to recommendations with a strength of recommendation grading system?

4. Are the guidelines unbiased and representative of a wide-range of clinicians?

5. Are the recommendations based on outcomes important to patients?

See LEADER NOTES for answers to discussion questions.
6. Are the interventions proposed in the guidelines feasible in all practice settings?

7. Have the guidelines been prospectively validated?

8. What are the major recommendations of the guidelines?

9. Are the guidelines expressed in terms we care about and can use?

HOW SHOULD THE NEW FINDINGS CHANGE CURRENT THERAPY?

10. Do the guidelines change your practice? How?

APPLY THE NEW FINDINGS TO THE FOLLOWING CASE

J.R. is an 83-year-old female with acute hypoxic respiratory failure secondary to pneumonia admitted from a nursing home. She was started on IV levofloxacin per hospital protocol. J.R.'s chronic meds (lisinopril 20 mg daily, metoprolol succinate 50 mg daily, and omeprazole 20 mg daily) were also continued on admission.

On day four of hospitalization, J.R. develops foul smelling, watery diarrhea and her stool test for C. difficile returns positive. You place J.R. on contact precautions.

See LEADER NOTES for answers to discussion questions.
11. What are J.R.’s risks for *C. difficile* diarrhea?

You try to narrow the spectrum of J.R.’s antibiotic. However, J.R.’s sputum culture did not reveal a pathogen, so you continue levofloxacin. She is improving clinically, so you switch her to oral levofloxacin and add a stop-date to the EHR to ensure the antibiotic doesn’t continue beyond seven days total treatment. Finally, you stop J.R.’s omeprazole, since you find no clear indication for a PPI.

12. How should you treat J.R.’s *C. difficile* diarrhea?

J.R. responds well to treatment. By day eight of hospitalization, J.R. no longer needs supplemental oxygen and her diarrhea has resolved. Your team feels she is stable for discharge.

J.R. is concerned about a recurrence of her diarrhea after she stops treatment, since her roommate struggled with many bouts of *C. diff* diarrhea. She is also worried about her daughter and grandchildren becoming infected with the same bacteria when they visit her. She asks if you can do a test to ensure that it has cleared before discharge, and if there is anything she can do to prevent future bouts of *C. diff*.

13. How should you advise J.R.? Should you retest her stool?

You discuss the BP effects of ibuprofen, and advise trying acetaminophen as an alternative. You also suggest a pill box to help M.B. organize his medications and remember whether he has taken them. M.B. and his daughter agree that switching to acetaminophen is worth a try, and that using a pill box sounds like a good idea.

You advise M.B. to return for a follow-up visit in one month to assess whether changes to his blood pressure medications are necessary.

See LEADER NOTES for answers to discussion questions.
REFERENCES


Additional Prescriber's Letter Resources available at PrescribersLetter.com

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