Management of Diarrhea in Hospitalized Patients

**Diagnosis**

If the patient is having diarrhea (≥3 loose stools in 24h), they should be placed on contact precautions, using gowns and gloves for all patient contact.

Send *C. difficile* toxin assay
   If negative, repeat the assay the next day.

If two assays are negative and the suspicion is still high for *C. difficile*
   Consider colonoscopy or sigmoidoscopy to look for pseudomembranes
   More than two toxin assays has little or no diagnostic yield

Consider other etiologies, such as tube feeding or medications.
Enteric pathogens are unlikely to cause diarrhea that was not present on admission, and parasitic infections even less so. Stool cultures and ova & parasite exams are generally not indicated.

**Treatment of *C. difficile* infection (CDI) is based on the severity of illness**

**Mild to Moderate**: minimal evidence of systemic illness.
   If possible, stop any other antibiotics the patient is on.
   Metronidazole 500 mg po TID or 250 mg po QID for 14 days
   Assess for response at 4 days, consider change to oral vancomycin.

**Severe**: Any of these signs OR 2 or more of the following

- Pseudomembranes seen on endoscopy
- Requires ICU treatment
- Known toxic genotype (NAP-1 or deletion mutant)
- Age > 60
- Temperature > 38.3 °C
- Albumin < 2.5 mg/dL
- WBC > 20,000 cells/mcl
- Acute Renal Failure

Vancomycin 125 mg po every 6 hours.
Add Metronidazole 500mg IV q8h in the most severe cases.
If oral drug is not reaching the rectum, vancomycin can be administered as 500 mg PR every 4 to 12 hours.
IV vancomycin therapy is not effective.

**Fulminant**: ileus, toxic megacolon, hypotension, or colonic perforation

Treat as for Severe CDI
Urgent surgical consultation
**Recurrent** disease
   First recurrence can be treated as you would initial disease
   Repeated recurrences should be referred to ID or GI for assistance.

**Duration of therapy** should be extended until broad-spectrum antibiotic therapy is complete, and should be no less than 10 days.

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<th>Contact Precautions</th>
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Patients should be put on isolation on suspicion of CDI.

Until the CDI is no longer suspected, patients should remain on contact precautions: private room, cover gowns and gloves for all contact. In cases with CDI, isolation should continue until they have completed therapy.

Consider ID or GI consultation for critically ill patients, patients not responding to therapy, or patients with recurrent disease.

For questions on these guidelines, call the Infectious Disease physician on call or Mark Shelly at 341-6821 (pager 220-8111).