Infectious Diseases Society of America
Emerging Infections Network

Comments for Query:
‘C. difficile Infections (CDI) in Pediatrics’

Comments made by 29 respondents.
State or province of practice shown in brackets, e.g., [CA]

CDI testing/treatment in infants

• The NICU case represents a major dilemma in Pediatric ID. The likelihood that with a positive test the infant in case 3 is having symptoms due to CDI is low, but likely not zero. If consulted, we would work to exclude other causes - rotavirus, adenovirus, norovirus, food sensitivity, and if no other cause were found, might give a trial of metronidazole. However, if you were to survey neonatologists, I fear many would test and treat all. [UT]

• We (ID) have little control regarding who gets tested, I think in my institution there is over testing, which is leading to over diagnosis and treatment. Regarding question 10, I would treat with IV metronidazole and if improvement is evident I would then complete course of rx, otherwise would stop after 3 days and look for other diagnoses [CA]

• I have a hard time convincing my colleagues that a (+) test in an infant is not helpful...have tried to get them to look at fecal WBCs, etc as further support for the condition before jumping to metronidazole therapy. [TN]

• Would use IV Flagyl for NEC [TX]

• Q10: [Would treat] if nothing else found and other antibiotics stopped and diarrhea persisted. [GA]

• How can we better educate primary care physicians NOT to test under a year of age? [DE]

• We do not encourage C. diff testing in children under a year of age but it is not forbidden. It gets done and no one who sends it knows what to do with the result. [NJ]

• Generally don't advocate treating for ages <6-12 months unless unusual circumstances [CA]

• In case 3 [Question 10], would probably feel forced to treat, if no cause identified, but I am skeptical that C diff is causal. [OR]

• Under the age of 2y, this is controversial. But if truly no other alternative diagnosis, often someone is treating and if coincident with the timing the baby gets better, it is difficult to form a convincing argument [KY]

• For Question 10: how symptomatic? If no blood, then consider watching. If s/s of invasive disease, then probably move toward treating. [NC]

• My answers to question 10a and 10b really would be "possibly"; depending upon if other causes of hospital associated diarrhea have been ruled out in this infant and depending upon the clinical status of the patient [PA]

• Although for infant C. diff is still unlikely, in absence of alternate diagnosis since there have been cases reports of pseudomembranous colitis in the first year of life, I may consider testing and treating- but this would definitely not be the norm. [MD]
• I never know what to do with infants <1 yo who are symptomatic and C. diff positive. I always err on the side of treating. Since we're not testing asymptomatic infants, I don't know what the true rate of positivity is. [IL]

• To address 10b. I have had 2 cases of C. diff in infants that we diagnosed by flexible sigmoidoscopy. We had empirically started on therapy given that all other testing had come back negative and both of these children had prolonged hospital courses and one developed toxic megacolon requiring surgery. It is NOT the norm to treat a positive C. diff assay in infants under 1 year of age- we base the decision to treat on the history, symptoms, physical exam and labs. [CA]

**Treatment of CDI in children**

• An option you did not allow was to do nothing - for mild disease this might be an option [NJ]

• Most of our Crohn's pts are on oral metronidazole a lot of the time anyway, so I wrestle with best approach for them. [TN]

• Clearly, we have uncertainty about what do in some pediatric settings, since much of the data is from adult studies. [CA]

• For question 9 if the patient were very ill I may try vanc per rectum. [CA]

• One of the most important options for C. diff management that is often ignored by clinicians is to discontinue the implicated antimicrobials. There appears to be a "compulsion" to treat when the optimal management may be to do nothing or restore gut flora with a probiotic. Rates of "CDI" are likely increasing because testing is easy and readily available. The disadvantage is that when an assay is C diff +, the work up/ evaluation usually ends. C diff is often a colonizing pathogen and the true etiology is not revealed. It is not infrequent that we see clinicians adding metronidazole to a regimen of meropenem after C diff is isolated. Thank you for putting together this survey and I would be happy to be involved with a discussion of the results. [GA]

• Normally I would not use IV metronidazole unless pt cannot take po. I would consider fidaxomicin or FMT if there are 3 or more recurrences in close proximity and the patient failed an oral vanco taper. [DE]

**Fecal Microbiota Transplantation (FMT)**

• We are seeing more interest in FMT. It is particularly easy to do with patients that have a G-tube. I have tried home fecal enemas but this does not seem to go as well in pediatrics since it is difficult for the children to retain the enema as well as the parental "ick factor". [MI]

• We have performed 2 FMTs at our institution and will be doing a third next week. [FL]

• Please let me know if there are any trials of FMT in pediatrics. [CA]

• We have performed 2 FMT achieving complete cure. One on a former BMT patient, and plan to perform another one in a toddler with significant comorbidities. Hopefully we will publish it soon. [FL]

• We have a few patients from whom fecal transplant might be beneficial, however developing a policy and procedure for doing so, has so far proved challenging. [CA]

**Epidemiology of CDI in pediatrics**

• Seeing an increasing numbers of recurrent CDI in Crohn's patients. [OH]

• Increased incidence of community-acquired CDI with no healthcare exposure [MN]

• Antimicrobial stewardship has significantly reduced our rate of CDI. [CA]

**Miscellaneous**

• AAP COID has statement coming out in next few months regarding CDI. [GA]

• We need to better understand the pathophysiology of CDI in children. [MN]