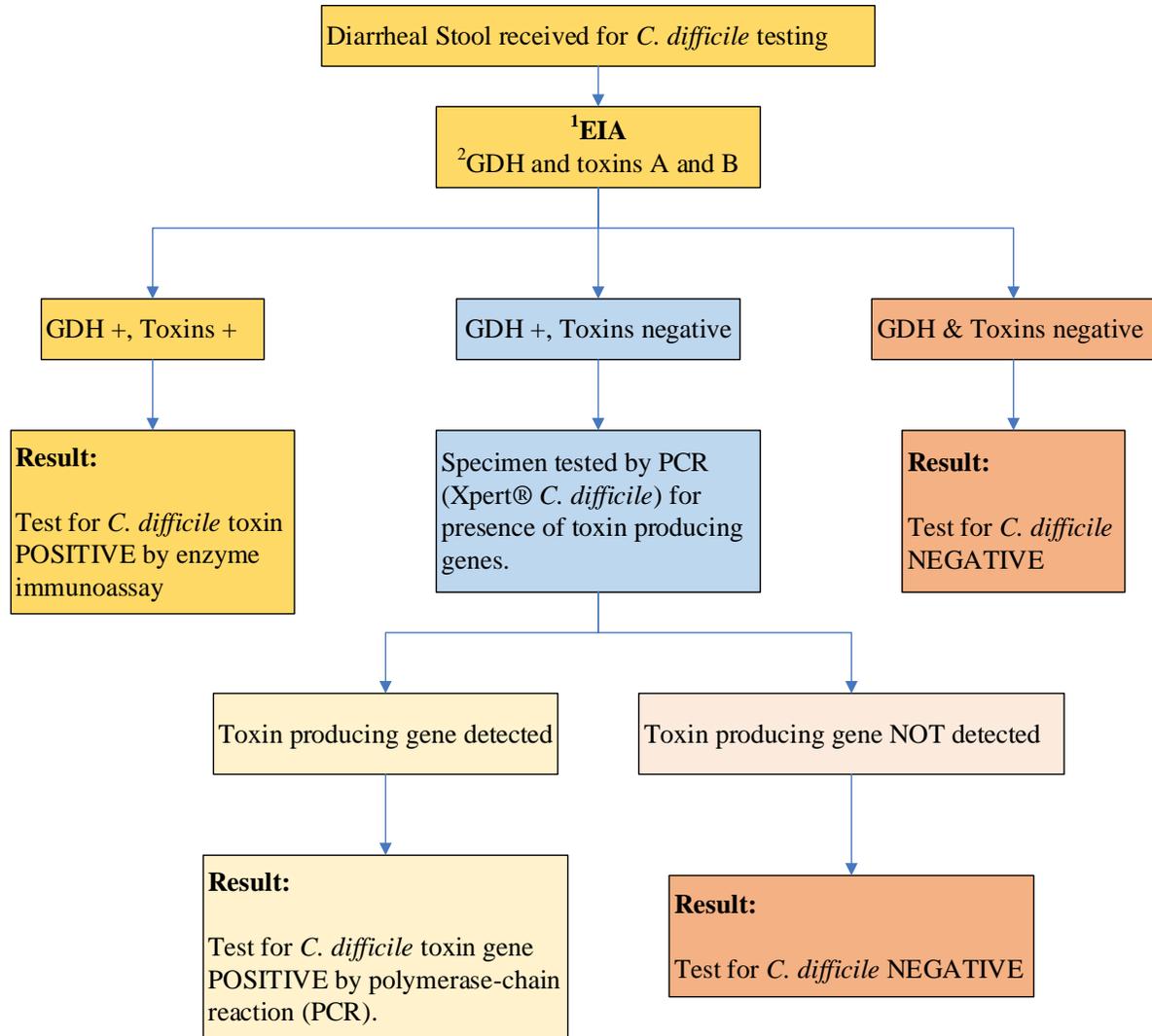


ProvLab *C. difficile* Testing, Results and Comments

C. difficile Testing Algorithm



Legend

¹EIA = Enzyme immunoassay
²GDH = glutamate dehydrogenase,
 an enzyme found in all *C. difficile*
 organisms

Result 1

Test for *C. difficile* NEGATIVE

Testing performed with C. DIFF QUIK CHEK COMPLETE® (Enzyme Immunoassay).

or

Test for *C. difficile* NEGATIVE

Testing performed with C. DIFF QUIK CHEK COMPLETE® (Enzyme Immunoassay) and Xpert® *C. difficile* (PCR).

Interpretation:

Testing did not detect toxin producing *C. difficile* in the specimen submitted.

Result 2

Test for *C. difficile* toxin POSITIVE by enzyme immunoassay.

Testing performed with C. DIFF QUIK CHEK COMPLETE® (Enzyme Immunoassay).

Interpretation:

Testing by EIA detected the presence of *C. difficile* toxin in the specimen submitted.

Result 3

Test for *C. difficile* toxin gene POSITIVE by polymerase-chain reaction (PCR).

This result can be seen in colonization, past infection, or possibly current infection. If the patient has diarrhea, the diagnosis of *C. difficile* infection and decision to treat should take into consideration other causes. IPC precautions are recommended for any patient with diarrhea.

Testing performed with C. DIFF QUIK CHEK COMPLETE® (Enzyme Immunoassay) and Xpert® *C. difficile* (PCR).

Interpretation:

Testing by EIA detected the presence of *C. difficile*, but **NOT** toxin A or B in the specimen submitted. PCR performed on the specimen detected the presence of the

toxin B producing gene of *C. difficile*. The clinical significance of this combination of results varies depending on whether the patient clinically fits the picture of colonization, past infection, or current infection. Other causes of diarrhea should be considered.

Note:

The production of *C. difficile* toxins is necessary for *C. difficile* colitis.

Due to the high sensitivity and the inability of nucleic acid amplification tests to distinguish *C. difficile* infection from asymptomatic carriage, over diagnosis of *C. difficile* colitis is a risk, with the added potential risk of treating patients with antibiotics when they may not require such therapy^{1,2}.

Result 4

CD toxin INCONCLUSIVE. Unable to confirm presence of *C. difficile* toxin. Indicates the presence of non-toxigenic *C. difficile*. Repeat if clinically indicated.

Testing performed with C. DIFF QUIK CHEK COMPLETE® (Enzyme Immunoassay) and Xpert® *C. difficile* (PCR).

Interpretation:

Testing by EIA was indeterminate for *C. difficile* and PCR performed on the specimen did **NOT** detect the presence of the toxin B producing gene of *C. difficile*; or the tests were invalid due to interfering substances in the specimen.

Note:

The production of *C. difficile* toxins is necessary for *C. difficile* colitis and there is no evidence that non toxigenic *C. difficile* can cause disease.

Colonization rates vary for different patient populations. Some published rates are:

- general population of healthy adults: 0 - 15%^{5, 10-20}
- long term care facility residents: 5 – 51%^{3-9, 20}
- acute care hospital inpatients: 4 – 29%²⁰
- healthy newborns and infants: 18 – 90%^{10,11}

Thus a patient with diarrhea and a *C. difficile* GDH antigen only positive, requires investigation for causes of diarrhea other than *C. difficile*.

References

1. Planche TD, Davies KA, Coen PG, et al. Differences in outcome according to Clostridium difficile testing method: a prospective multicentre diagnostic validation study of C difficile infection. *Lancet Infect Dis* 2013; 13:936.
2. Polage CR, Gyorko CE, Kennedy MA, et al. Overdiagnosis of Clostridium difficile Infection in the Molecular Test Era. *JAMA Intern Med* 2015; 175:1792.
3. 46. Bender B, Laughon B, Gaydos C, Forman M, Bennett R, Greenough WB, III, Sears S, Bartlett J. Is Clostridium difficile endemic in chronic care facilities? *The Lancet*. 1986; 328:11–13. [PubMed]
4. Simor AE, Yake SL, Tsimidis K. Infection Due to Clostridium difficile Among Elderly Residents of a Long-Term-Care Facility. *Clin. Infect. Dis.* 1993; 17:672–678. [PubMed]
5. Arvand M, Moser V, Schwehn C, Bettge-Weller G, Hensgens MP, Kuijper EJ. High Prevalence of Clostridium difficile Colonization among Nursing Home Residents in Hesse, Germany. *PLoS ONE*. 2012; 7:e30183. [PMC free article] [PubMed]
6. Marciniak C, Chen D, Stein AC, Semik PE. Prevalence of Clostridium difficile Colonization at Admission to Rehabilitation. *Arch. Phys. Med. Rehabil.* 2006; 87:1086–1090. [PubMed]
7. Riggs MM, Sethi AK, Zabarsky TF, Eckstein EC, Jump RLP, Donskey CJ. Asymptomatic Carriers Are a Potential Source for Transmission of Epidemic and Nonepidemic Clostridium difficile Strains among Long-Term Care Facility Residents. *Clin. Infect. Dis.* 2007; 45:992–998. [PubMed]
8. Bartlett JG. Antibiotic-Associated Diarrhea. *N. Engl. J. Med.* 2002; 346:334–339. [PubMed]
9. Rea MC, O’Sullivan O, Shanahan F, O’Toole PW, Stanton C, Ross RP, Hill C. Clostridium difficile Carriage in Elderly Subjects and Associated Changes in the Intestinal Microbiota. *J. Clin. Microbiol.* 2011 [PMC free article] [PubMed]
10. Viscidi R, Willey S, Bartlett JG. Isolation rates and toxigenic potential of Clostridium difficile isolates from various patient populations. *Gastroenterology*. 1981; 81:5–9. [PubMed]
11. Rousseau C, Levenez F, Fouqueray C, Dore J, Collignon A, Lepage P. Clostridium difficile colonization in early infancy is accompanied by changes in intestinal microbiota composition. *J Clin Microbiol.* 2011; 49:858–65. [PMC free article] [PubMed]
12. Stojanović P, Stojanović N, Kocic B, Stanković-Dordević D, Babić T, Stojanović K. Asymptomatic carriers of Clostridium difficile in Serbian population. *Cent Eur J Med.* 2012; 7:769–74.
13. Ozaki E, Kato H, Kita H, Karasawa T, Maegawa T, Koino Y, et al. Clostridium difficile colonization in healthy adults: transient colonization and correlation with enterococcal colonization. *J Med Microbiol.* 2004; 53:167–72. [PubMed]
14. Miyajima F, Roberts P, Swale A, Price V, Jones M, Horan M, et al. Characterization and carriage ratio of Clostridium difficile strains isolated from a community-dwelling elderly population in the United Kingdom. *PLoS ONE*. 2011;6 [PMC free article] [PubMed]

15. McNamara SE, Abdujamilova N, Somsel P, Gordoncillo MJ, DeDecker JM, Bartlett PC. Carriage of *Clostridium difficile* and other enteric pathogens among a 4-H avocational cohort. *Zoonoses Public Health*. 2011; 58:192–9. [PubMed]
16. Aronsson B, Mollby R, Nord CE. Antimicrobial agents and *Clostridium difficile* in acute enteric disease: Epidemiological data from Sweden, 1980–1982. *J Infect Dis*. 1985; 151:476–81. [PubMed]
17. Kato H, Kita H, Karasawa T, Maegawa T, Koino Y, Takakuwa H, et al. Colonization and transmission of *Clostridium difficile* in healthy individuals examined by PCR ribotyping and pulsed-field gel electrophoresis. *J Med Microbiol*. 2001; 50:720–7. [PubMed]
18. Galdys AL, Nelson JS, Shutt KA, Schlackman JL, Pakstis DL, Pasculle AW, et al. Prevalence and duration of asymptomatic *Clostridium difficile* carriage among healthy subjects in Pittsburgh Pennsylvania. *J Clin Microbiol*. 2014; 52:2406–9. [PMC free article] [PubMed]
19. Belmares J, Johnson S, Parada JP, Olson MM, Clabots CR, Bettin KM, et al. Molecular epidemiology of *Clostridium difficile* over the course of 10 years in a tertiary care hospital. *Clin Infect Dis*. 2009; 49:1141–7. [PubMed]
20. Luis Furuya-Kanamori, John Marquess, Laith Yakob, Thomas V. Riley, David L. Paterson, Niki F. Foster, Charlotte A. Huber, and Archie C. A. Clement. Asymptomatic *Clostridium difficile* colonization: epidemiology and clinical implications. *BMC Infect Dis*. 2015; 15: 516.