

Clostridium *difficile* Subcommittee Meeting
July 29, 2010

Access Information

Toll Free Number: (866) 910-5406
Participant Passcode: 8625307

Clostridium *difficile* Subcommittee Meeting Minutes – 7/29/10

I agreed to be the note taker for the *C. difficile* subcommittee and I apologize for being late in reporting. All the members of the subcommittee were in attendance:

Shannon Oriola

Rekha Murthy

Dawn Terashita

Ray Chinn

Francesca Torriani

Kim Boynton-Delahanty

Plus staff members Denise Bonilla and Jon Rosenberg

The primary discussion item, reflecting the first agenda item below (pros and cons of Lab-ID reporting vs. IP surveillance) was the public attribution of CDI rates to hospitals. The crux of this issue is that hospital onset CDO often is the result of acquisition of the organism elsewhere, and the development of illness during hospitalization, while the public likely perceive that if the illness occurs in the hospital then the organism is acquired in the hospital. While public education was cited as a key to public understanding of the complexities and meaning of CDI rates, there was continued skepticism expressed by a number of members in regard to the public appreciating the issues.

This led to discussion of definitions used in an ICHE article by Cliff McDonald in regard to differentiating hospital onset cases attributable or not-attributable to hospital factors. I have not been able to find such an article but perhaps another member can forward one to the group. The attached article of which Cliff is a co-author uses the term “healthcare facility (HCF)-onset, HCF-associated CDI: but does not include any category of HCF-onset CDI other than HCF-associated. This article also provides a case definition of: (1) the presence of diarrhea, defined as passage of 3 or more unformed stools in 24 or fewer consecutive hours¹⁻⁸; (2) a stool test result positive for the presence of toxigenic *C. difficile* or its toxins or colonoscopic or histopathologic findings demonstrating pseudomembranous colitis. There is no discussion of excluding the diagnosis in the presence of other potential causes of diarrhea.

There was some discussion about the differences between lab and clinical surveillance. Rekha (I believe said that when they looked at the difference in rates between their clinical surveillance and NHSN LabID rates, the NHSN rate was 2.5 times higher than clinical. I didn’t think to ask at that time if the NHSN rate was clearly hospital onset only; that could explain some of the discrepancy. This large a discrepancy should not be

solely or even primarily the result of differences in judging whether a toxin-positive patient with diarrhea should or shouldn't be judged to be a CDI case, but must reflect differences in case finding. This might be worth pursuing further.

Cliff McDonald and Dawn Sievert have agreed to participate by phone at our next meeting.

Next meeting will take place on 8/12/10 from 9:00am-10:00am