Background

C. difficile infection (CDI) varies in severity in different patient groups. In patients with inflammatory bowel disease (IBD), CDI is a risk factor for both morbidity and mortality. Interaction between the two disease processes may result in more severe CDI than either condition alone. Currently there is a paucity of data concerning outcomes in patients with IBD who also have CDI, meaning that the appropriate choice of treatment strategy may be unclear. Guidance on best practice in the treatment of CDI in patients with IBD is therefore needed urgently.

Objectives

This consensus project aims to discuss and clarify the management of these patient outcomes, to identify and address areas of controversy in the management of CDI in patients with IBD. Areas of controversy can thus be identified and addressed in order to improve outcomes.

Methodology

A multidisciplinary group of clinicians who treat patients with IBD and CDI met in May 2015 to discuss and clarify the management of these patients. Six key themes were identified and following further discussion, 27 consensus statements (Table 1) were developed and submitted to respondents from around the world by questionnaire at conferences and congresses. Statements were grouped into six themes as shown in Table 1.

Respondents were asked to rate their agreement with each statement using a 6-point Likert scale. A modified Delphi methodology was used to review responses. In accordance with Best Practice, a level of 75% agreement was defined as a threshold for consensus for each statement.

Results

423 respondents completed questionnaires, distributed across the professional roles shown in Table 2. 361 respondents were from Europe.

Conclusion

This research suggests that physicians consider that treatment strategy for CDI in IBD should be driven by risk factors for poor outcome rather than being solely defined by severity of disease. In addition, a uniformly accepted definition for recurrent CDI is needed for patients with IBD. A common approach for CDI in IBD would reduce variation in clinical practice between specialists and to achieve this, clinicians should be familiar with the role responsibilities of other specialists in managing CDI in IBD. Higher quality evidence is required to inform future CDI guidelines, including clarity regarding the adjustment of immunosuppression in patients with CDI. More data is required to define the place for faecal microbiota transplantation in CDI patients with IBD.