

**P1099**

**Paper Poster Session**

**Clostridium difficile: epidemiology and risk factors**

**IBD and CDI: the contrasting views of different clinical professionals across Europe**

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**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 increase severity of colitis. Currently there is a paucity of data concerning outcomes in patients with IBD who 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. This consensus project examines the issues impacting clinical professionals working with CDI. It aims to understand the perceptions and attitudes of key stakeholders regarding best practice in the management of CDI in patients with IBD. In turn, guidance and clarity may be offered to practitioners based on the attitudes of their peers in order to improve patient

**Material/methods:** A multidisciplinary group of clinicians involved in the treatment of patients with IBD and CDI met in May 2015 with the objective of defining themes for clarification in the management of CDI, with a focus on CDI in patients with IBD. 27 consensus statements were developed and submitted to respondents from around the world by questionnaire at conferences and congresses. Respondents were asked to rate their agreement with each statement using a 4-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:** Responses were received from 426 respondents. The largest single group was infectious disease specialists (n=104), followed by microbiologists (n=95) and gastroenterologists (n=63). 17 of the 27 statements (62.9%) achieved consensus with agreement scores of 75% or greater. Differences

were observed between the perceptions of microbiologists and gastroenterologists as well as between countries. Without prompting, recognition of risk factors was low amongst clinicians, this suggests a model for scoring symptom severity is required. In addition, clarity regarding clinical definitions of recurrent CDI is needed.

**Conclusions:** 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 to CDI in IBD would reduce variance in clinical practice between specialties and to achieve this, clinicians should be familiar with the role responsibilities of other specialties 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 IBD. More data are required to define the place for faecal microbiota transplantation in CDI patients with IBD.