Treatment of (recurrent) Clostridioides difficile Infections in Children and Adults

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Letters to the Editor: Treatment of (recurrent) *Clostridioides difficile* infections in children and adults

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We congratulate the NASPGHAN and ESPGHAN with the joint position paper on Fecal Microbiota transplantation for multiple recurrent *Clostridioides difficle* infections (rCDI) and other diseases (1). Unfortunately, robust data assessing the optimal approach for treating an initial episode of CDI in children are limited and most evidence derives from adult studies. The recommendations of the European and American societies for treatment of adults with rCDI have some similarities, but also important differences (2,3). In adults, metronidazole is no longer considered a first choice treatment option for CDI, whereas it has a prominent place in the pediatric guideline (2,3). In adults, vancomycin and fidaxomicin are preferred over metronidazole. In children, a randomised controlled trial comparing oral vancomycin and fidaxomicin has recently been completed (NCT02218372) with preliminary data suggesting acceptable efficacy and safety for fidaxomicin. Fidaxomicin and the potential future availability of bezlotoxumab for children (see NCT03182907) deserve a more prominent place in this position paper instead of following a 6- to 8-week taper treatment with vancomycin with or without rifaximin and nitazoxanide (4). Considering the intensive collateral damage vancomycin causes in the gut microbiota of children and adults alike, we would encourage exploration of microbiota-sparing alternatives. In this sense, we agree that fecal microbiota transplantation (FMT) should be considered for treatment of children with multiple rCDI, and that FMT should be performed in established centers where long term side effects can be monitored. Prospective multicenter follow-ups are necessary, especially in children, since it remains unclear whether healthy adults or age matched children are preferred donors. Therefore, national non-profit universal donor feces banks should be established that provide services to both adults and children. In addition, these centers should promote the exchange of experiences between specialists working with adults and children (5). Finally, we believe Table 2 (Recommended stool donor screening) lists only part of the required serum and stool testing of potential donors, so we suggest the providers refer to the published recommendations of Terveer et al (5).

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