To develop a European surveillance protocol for *Clostridium difficile* infection (CDI), existing national CDI surveillance systems were assessed in 2011. A web-based electronic form was provided for all national coordinators of the European CDI Surveillance Network (ECDIS-Net). Of 35 national coordinators approached, 33 from 31 European countries replied. Surveillance of CDI was in place in 14 of the 31 countries, comprising 18 different nationwide systems. Three of 14 countries with CDI surveillance used public health notification of cases as the route of reporting, and in another three, reporting was limited to public health notification of cases of severe CDI. The CDI definitions published by the European Society of Clinical Microbiology and Infectious Diseases (ESCMID) and the European Centre for Disease Prevention and Control (ECDC) were widely used, but there were differing definitions to distinguish between community- and healthcare-associated cases. All CDI surveillance systems except one reported annual national CDI rates (calculated as number of cases per patient-days). Only four surveillance systems regularly integrated microbiological data (typing and susceptibility testing results). Surveillance methods varied considerably between countries, which emphasises the need for a harmonised European protocol to allow consistent monitoring of the CDI epidemiology at European level. The results of this survey were used to develop a harmonised EU-wide hospital-based CDI surveillance protocol.

**Introduction**

Since 2000, a considerable increase in the number of *Clostridium difficile* infections (CDIs) leading to substantial morbidity, mortality and attributable costs has been observed, at least in North America and Europe [1]. Changes in the epidemiology of CDI have been mainly attributed to the emergence of a new hyper-virulent strain called PCR ribotype 027, causing numerous outbreaks in North America and Europe [2,3] and, to a lesser extent, PCR ribotype 078 [1,4,5]. In addition, patients not previously considered to be at risk for the disease (e.g., without recent antibiotic therapy or hospitalisation) have also been described [1,6-8]. The European CDI study (ECDIS), initiated and funded by the European Society of Clinical Microbiology and Infectious Diseases (ESCMID) and the European Centre for Disease Prevention and Control (ECDC), showed that the incidence of CDI varied from hospital to hospital [9]. In 2008, a weighted mean incidence of 4.1 cases (range: 0.0–36.3) per 10,000 patient-days per hospital reported by the ECDIS study was almost 70% higher than that reported in a previous European surveillance study in 2005 (2.45 cases per 10,000 patient-days per hospital, range: 0.13–7.1) [9,10]. ECDIS also revealed the contribution of strains other than PCR ribotype 027 and that some of these strains, notably PCR ribotypes 015, 018 and 056, could cause severe CDI.

In response to the emerging problems associated with *C. difficile*, an ECDC working group published background information about the changing epidemiology of CDI, CDI case definitions and surveillance recommendations [2]. To support European Union (EU)/European
## Table

Characteristics of European *Clostridium difficile* infection surveillance systems, 2011 (18 surveillance systems from 14 countries)

<table>
<thead>
<tr>
<th>Country</th>
<th>Name</th>
<th>Participants</th>
<th>General remarks</th>
<th>Epidemiological data</th>
<th>Microbiological data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>No name</td>
<td>All H/L/G</td>
<td>M C + P Lb + Cb only sevCDI</td>
<td>Total number CDI-days</td>
<td>RTcp AST</td>
</tr>
<tr>
<td>Belgium</td>
<td>National Surveillance of Infections in Hospitals (NSIH)</td>
<td>110 H</td>
<td>M P Cb periodic (6 months a year)</td>
<td>HA-CDI: I (1,000 pa/6 months) Id (10,000 pd/6 months) Severe CDI: ICU-adm/death within 30 days related to CDI</td>
<td>TcdT (fp/sevCDI/ob) AST (fp/sevCDI/ob)</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>BGCDISS</td>
<td>6 H/3 L</td>
<td>V C + P Lb + Cb</td>
<td>HA-CDI: I (10,000 pa) Id (10,000 pd)</td>
<td>RTcp No AST</td>
</tr>
<tr>
<td>Denmark</td>
<td>Surveillance of epidemic hypervirulent CD in Denmark</td>
<td>13 H/13 L</td>
<td>V C + P Lb</td>
<td>I (number of episodes/region)</td>
<td>RTag (sevCDI+MaxR/ob) AST</td>
</tr>
<tr>
<td>Finland-1</td>
<td>National Infectious Diseases Register</td>
<td>All L</td>
<td>M C + P Lb</td>
<td>I (100,000 inh)</td>
<td>RTag (sevCDI/ob) No AST</td>
</tr>
<tr>
<td>Finland-2</td>
<td>Finnish Hospital Infection Programme (SIRO)</td>
<td>12 H</td>
<td>V C + P Cb</td>
<td>HA-CDI: I (100 inh)</td>
<td>None</td>
</tr>
<tr>
<td>Finland-3</td>
<td>National Hospital Discharge Register (HILMD)</td>
<td>57 H</td>
<td>M C (retrosp.) ICD 10-based</td>
<td>I (CDI hospitalisations/100,000 inh)</td>
<td>None</td>
</tr>
<tr>
<td>France</td>
<td>Healthcare acquired Infections Early warning and Response system</td>
<td>100 H/115 L/10 N</td>
<td>M C + P Cb only sevCDI/ob</td>
<td>Severe CDI: Total number: I (1,000 pa) Id (100 pd)</td>
<td>RTag (sevCDI/ob) AST (sevCDI/ob)</td>
</tr>
<tr>
<td>Germany-1</td>
<td>CDAD-KISS</td>
<td>126 H</td>
<td>V C + P Cb</td>
<td>HA-CDI (severe CDI): I (100 adm) Id (1,000 pd)</td>
<td>None</td>
</tr>
<tr>
<td>Germany-2</td>
<td>SurvNet</td>
<td>About 2000 H</td>
<td>M C + P Cb only sevCDI/ribotype 027</td>
<td>Severe CDI: Total number: I (100,000 inh/ICU-adm/surgery/death within 30 days related to CDI)</td>
<td>RTcp (sevCDI/ob) No AST</td>
</tr>
<tr>
<td>Hungary</td>
<td>Epidemiological Control System and Information System (EFRIR)</td>
<td>35 H / 14 L</td>
<td>M C + P Lb + Cb</td>
<td>Total number</td>
<td>RTag (sevCDI/ob) No AST</td>
</tr>
<tr>
<td>Ireland-1</td>
<td>Notifiable <em>C. difficile</em> Surveillance</td>
<td>48 H/37 L / all G from 8 public health regions</td>
<td>M C + P Cb</td>
<td>I (100,000 inh)</td>
<td>None</td>
</tr>
<tr>
<td>Ireland-2</td>
<td><em>C. difficile</em> Enhanced Surveillance</td>
<td>34 H/34 L</td>
<td>V C + P Cb</td>
<td>HA-CDI: Id (100 pd) Severe CDI: ICU-adm/surgery related to CDI</td>
<td>None</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>Sentinel surveillance of <em>C. difficile</em></td>
<td>19 H/19 L</td>
<td>V C + P Cb only sevCDI/ribotype 027</td>
<td>HA-CDI: I (CDI cases/pa) Id (CDI cases/pd)</td>
<td>RTag (fp) No AST</td>
</tr>
<tr>
<td>Sweden</td>
<td>National Laboratory-based CD Surveillance System</td>
<td>20 L</td>
<td>V C + P Lb</td>
<td>Total number</td>
<td>RTac (fp/sevCDI/ob) AST (fp)</td>
</tr>
<tr>
<td>UK-England</td>
<td>HCAI Data Capture System</td>
<td>167 NHS Acute Trusts with 1-2 H each</td>
<td>M C + P Lb</td>
<td>All types of CDI: Id (adm165 y/1,000 pd) HA-CDI: Id (cases12 y/10,000 pd) Severe CDI: Death within 30 days related to CDI</td>
<td>RTca AST (fp)</td>
</tr>
<tr>
<td>UK-Northern Ireland</td>
<td>Enhanced HCAI Web-based Surveillance System</td>
<td>28 H/5 L / 38 GP / 240 L / 337 R</td>
<td>M C + P Lb</td>
<td>HA-CDI and CA-CDI: Total number Id (1,000 pd)</td>
<td>RTcp/no AST</td>
</tr>
<tr>
<td>UK-Scotland</td>
<td>Scottish Mandatory Surveillance Programme for CDI</td>
<td>23 L and 14 NHS health boards including H/N/G</td>
<td>M C + P Lb</td>
<td>HA-CDI: Id (cases15 y/1000 pd)</td>
<td>RTag (fp/sevCDI/ob) AST (fp/sevCDI/ob)</td>
</tr>
</tbody>
</table>

ac: acrylamide; adm: admissions; ag: agarose; AST: antimicrobial susceptibility testing; C: continuous; CA: community associated; cp: capillary; Cb: case-based; CD: *Clostridium difficile*; CDI: *Clostridium difficile* infection; fp: fixed proportion; G: general practitioners; H: hospitals; HA: healthcare associated; I: incidence; ICD-10: International Statistical Classification of Diseases 10th revision; ICU: intensive-care unit; Id: incidence density; inh: inhabitants; L: laboratories; Lb: laboratory-based; M: mandatory; MoxR: moxifloxacin resistance; N: nursing homes; ob: outbreaks; pa: patient admissions; pd: patient-days; R: residential homes; retrosp.: retrospective; RT: ribotyping; sevCDI: severe CDI; TcdC: typing of the *tcdC* gene; UK: United Kingdom; V: voluntary; y: years.

1. Iceland and UK-Wales did not reply to the web-based questionnaire.
2. Some countries had more than one surveillance system in parallel. Where relevant, they are shown with the suffixes -1, -2 and -3.
Economic Area (EEA) Member States in increasing their capacity for CDI surveillance, ECDC also initiated and funded a new project – ECDIS-Net – to develop a European surveillance protocol and enhance laboratory capacity for diagnosis and typing of \textit{C. difficile} in EU/EEA Member States.

In 2011, a survey of existing CDI surveillance systems in European countries was performed as part of the ECDIS-Net project. The results of this survey, presented here, were later used to develop a standardised pan-European CDI surveillance protocol, which was tested in a three-month pilot study in 2013 [11]. Data collection in the ECDC-coordinated Europe-wide hospital-based CDI surveillance, using a finalised version of this pilot protocol, began on 1 January 2016 [12].

**Methods**

National coordinators for this study were identified through the members of ECDC’s Healthcare-Associated Infections surveillance Network (HAI-Net) and via representatives for the ECDIS study [9]. A link to a web-based questionnaire was sent to these national coordinators to assess the characteristics of existing CDI surveillance systems in European countries. If the national coordinators indicated that CDI was under surveillance in their country, the surveillance protocols were requested and used to augment the information obtained via the questionnaire. Information on the national CDI surveillance systems was entered using a web-based electronic form designed for the purpose of this study.

**Results**

Between 6 June and 15 July 2011, 33 of the 35 national coordinators approached from 31 European countries responded to the web-based questionnaire (Iceland and Wales did not respond). Four surveillance systems were excluded from further analysis, as they were not ongoing, comprehensive nationwide surveillance systems, i.e. they were completed one-off studies (two studies from Spain), only regional (Switzerland) or focused only on outbreaks (one system of the Netherlands). In 14 countries, the national coordinators indicated that CDI was under surveillance in their country, the surveillance protocols were requested and used to augment the information obtained via the questionnaire. Information on the national CDI surveillance systems was entered using a web-based electronic form designed for the purpose of this study.

In Austria, France and Germany-2, surveillance of CDI targeted severe cases only. All surveillance systems included CDI in hospitalised patients, but 10/18 systems also included patients with community-acquired CDI. CDI case ascertainment was case-based (including clinical evaluation) in 7/18 systems, laboratory-based (relying on positive test results for toxin-producing \textit{C. difficile}) in 5/18 systems or a combination of both in an additional 5/18 surveillance systems. Only Finland-3 used the International Statistical Classification of Diseases 10th revision (ICD-10)-based discharge coding [13] to find cases of CDI.

**Definitions of \textit{C. difficile} infection**

The definitions used for CDI surveillance are summarised in the Box.

The majority (12/18) of the surveillance systems used the ECDC and CDC case definition of CDI [2,14], 4/18 used other definitions and 2/18 did not use a specific case definition (but relied instead on the diagnosis of the attending physician and a positive laboratory test result for toxigenic \textit{C. difficile}). More detailed definitions for community-associated CDI, community-onset of healthcare-associated CDI and healthcare-onset of healthcare-associated CDI were used by 9/18 (ECDC definition: 7/9, other definitions: 2/9). Definitions differing from ECDC’s for community-associated CDI, community-onset healthcare-associated CDI and healthcare-onset healthcare-associated CDI used a time point of ≥ 72 hours or > 3 days (i.e. on or after day 4 of admission) instead of ≥ 48 hours between admission and onset of symptoms to distinguish between community- and healthcare-associated CDI.

In 13/18 surveillance systems, there was a definition for severe cases of CDI (ECDC definition: 5/13, other definitions: 8/13) and in 11/18 systems, there was also a definition for recurrence of CDI (ECDC definition: 9/11, other definitions: 2/11). Definitions differing from ECDC’s definition for severe/complicated course of CDI used additional criteria such as bloody diarrhoea, temperature > 38.5°C, white cell count > 15 × 10⁹/L, decreased kidney function or hypo-albuminaemia (< 30...
In 8/18 surveillance systems, case-based data were used hospital administration data only (Finland-3). Surveillance teams, and in 5/18 by both. One surveillance system used only by laboratories, in 7/18 only by infection control teams, and in 5/18 by both. One surveillance system relied solely on laboratory tests positive for CDI without additional patient data (Denmark, Finland-1, Sweden).

The collected data were pooled nationwide in 11/18 surveillance systems (Belgium, Bulgaria, Finland-1, Finland-3, France, Hungary, Ireland-1, Ireland-2, Portugal, and Sweden).

**Box**

**Definitions, including surveillance system-specific definitions**, for surveillance of *Clostridium difficile* infections

<table>
<thead>
<tr>
<th>CDI case</th>
<th>A patient to whom one or more of the following criteria applies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>diarrhoeal stools or toxic megacolon AND a positive laboratory assay for <em>C. difficile</em> TcdA and /or TcdB in stools or a toxin-producing <em>C. difficile</em> organism detected in stool via culture or other means;</td>
</tr>
<tr>
<td>2.</td>
<td>colonic histopathology characteristic of CDI (with or without diarrhoea) on a specimen obtained during endoscopy, colectomy or autopsy;</td>
</tr>
</tbody>
</table>

**Differing definitions:**
- Finland-1: Detection of *C. difficile* organism/DNA/RNA/toxin in a clinical sample.
- Finland-3: International Classification of Diseases (ICD)-10 codes A04.7 and K52.8 specific for *Clostridium difficile*-associated disease.
- France: In addition: white cell count > 20 × 10^3/mm^3.
- Germany: Instead of 1: Readmission because of recurrent CDI (points 2–4 as above)
- Hungary: Death linked to CDI (based on death register).
- Ireland-2: 1. Admission to an intensive care unit for treatment of CDI or its complication (e.g. for shock requiring vasopressor therapy) and/or 2. surgery (colectomy) for toxic megacolon, perforation or refractory colitis.
- The Netherlands: 1. Bloody diarrhoea and/or 2. pseudomembranous colitis and/or 3. diarrhoea in combination with dehydration and/or hypo-albuminaemia (< 30 g/L) 4. temperature > 38°C and white cell count > 15 × 10^9/L, decreased kidney function, or evidence of colitis.
- UK-Scotland: In addition: Endoscopic diagnosis of pseudomembranous colitis (with or without toxin confirmation) persisting CDI where the patient has remained symptomatic and toxin positive despite two courses of appropriate therapy.

**Community-associated CDI**

Onset of CDI outside a healthcare facility (HCF) or within 48 hours following admission to a healthcare facility without residence in/discharge from a healthcare facility within the previous 12 weeks.

**Differing definitions:**
- Finland-2 and Germany-1: Onset of CDI in an outpatient or inpatient within 72 hours after admission to the facility.
- UK-England: A positive specimen taken more than 28 days after the initial specimen is considered a new CDI episode.

**Complicated course of CDI (severe CDI case)**

A patient to whom any of the following criteria applies:
- 1. admission to a healthcare facility for treatment of community-associated CDI;
- 2. admission to an intensive-care unit for treatment of CDI or its complication (e.g. for shock requiring vasopressor therapy); surgery (colectomy) for toxic megacolon, perforation or refractory colitis;
- death within 30 days after diagnosis, if CDI is either the primary or a contributive cause.

**Differing definitions:**
- Austria: CDI requiring admission to an intensive-care unit/CDI requiring surgery/fatal cases of CDI.
- Germany: Instead of 1: Readmission because of recurrent CDI (points 2–4 as above)
- France: In addition: white cell count > 20 × 10^3/mm^3.
- Hungary: Death linked to CDI (based on death register).
- Ireland-2: 1. Admission to an intensive care unit for treatment of CDI or its complication (e.g. for shock requiring vasopressor therapy) and/or 2. surgery (colectomy) for toxic megacolon, perforation or refractory colitis.
- The Netherlands: 1. Bloody diarrhoea and/or 2. pseudomembranous colitis and/or 3. diarrhoea in combination with dehydration and/or hypo-albuminaemia (< 30 g/L) 4. temperature > 38°C and white cell count > 15 × 10^9/L, decreased kidney function, or evidence of colitis.
- UK-Scotland: In addition: Endoscopic diagnosis of pseudomembranous colitis (with or without toxin confirmation) persisting CDI where the patient has remained symptomatic and toxin positive despite two courses of appropriate therapy.

**Recurrent CDI**

An episode of CDI that occurs > 2 weeks and ≤ 8 weeks following the onset of a previous episode.

**Differing definitions:**
- UK-England: A positive specimen taken more than 28 days after the initial specimen is considered a new CDI episode.
- UK-Scotland: A new episode is defined as one occurring more than 28 days after the previous onset.

---

CDI: *Clostridium difficile* infection; UK: United Kingdom.

* Some countries had more than one surveillance system in parallel.

Source: [2,14]. Surveillance system-specific definitions: this study.

Definitions differing from those used by ECDC for recurrent CDI used a time lapse of between two and four weeks after the previous onset to distinguish between different episodes of CDI.

**Collection of *C. difficile* infection surveillance data**

In 5/18 surveillance systems, data collection was done only by laboratories, in 7/18 only by infection control teams, and in 5/18 by both. One surveillance system used hospital administration data only (Finland-3). In 8/18 surveillance systems, case-based data were collected by healthcare personnel (in 7/8 in combination with the infection control teams). In addition, general practitioners were engaged in surveillance data collection in Austria and UK-Scotland, as were public health doctors in Ireland-1. Only 3/18 surveillance systems relied solely on laboratory tests positive for CDI without additional patient data (Denmark, Finland-1, Sweden).
Sweden, UK-Northern Ireland and UK-Scotland), per
district or health board in 9/18 systems (Austria,
Denmark, Finland-1, Finland-3, France, Germany-2,
Ireland-1, UK-Northern Ireland and UK-Scotland),
per healthcare facility in 9/18 systems (Belgium,
Bulgaria, Finland-2, France, Germany-1, Ireland-2,
the Netherlands, UK-England, UK-Northern Ireland)
and per unit within a healthcare facility in 2/18 sys-
tems (Finland-2, UK-Northern Ireland). In Finland-3
and Sweden, the collected data were also pooled per
laboratory. Data about the size or type of the reporting
healthcare facility were collected in 12/18 CDI surveil-
lance systems, but not in the remaining six systems
(Austria, Denmark, Finland-1, Germany-2, Hungary,
Sweden). In 8/18 surveillance systems, even the spe-
ciality of the reporting unit or department was known.
Most of the surveillance systems collected patient
data: age and sex of CDI cases were reported in 16/18
surveillance systems, the date of onset of CDI in 13/18
systems and the date of admission in 11/18 systems.
Only one surveillance system did not collect any patient
data (Germany-1). Data about the history of CDI cases
were collected in 6/18 surveillance systems (number
of previous hospital admissions: 2/6, number of previ-
ous episodes of CDI: 4/6; recurrent CDI: 5/6) and data
about the outcome of CDI (death within 30 days) were
collected in 5/18 systems.

Reporting of *C. difficile* infection surveillance
data
CDI surveillance results were periodically reported in
16/18 surveillance systems (ranging from daily reports
in UK-Northern Ireland to annual reports in 9/18 sys-
tems); only 2/18 surveillance systems did not report the
results at regular intervals (Finland-3, Germany-2). All
18 surveillance systems published their reports nation-
ally, but in 6/18 and 3/18 surveillance systems, there
were additional regional and local reports, respecti-
vously. Most (12/18) of these reports were available
to the public and healthcare professionals; only 4/18
and 2/18 surveillance systems published reports that
solely targeted healthcare professionals or the pub-
lic, respectively. Surveillance results were stratified
in 8/18 surveillance systems, mostly by geographical
region (4/8) or type of healthcare facility (4/8). More
details, including denominators and calculated CDI
rates, are given in the Table.

Typing
Typing of *C. difficile* was performed by national refer-
ence laboratories in 13 European countries with CDI
surveillance, PCR ribotyping (either agarose: 8/13,
acrylamide: 1/13 or capillary gel-based: 4/13) being
the preferred method. Only one reference laboratory
also used tcdC typing (Belgium). For the purposes of
surveillance, typing was done in 13/18 European sur-
veillance systems with varying criteria for submitting
strains for further typing: severe CDI (9/13), outbreaks
(7/13), isolates resistant to moxifloxacin (Denmark) or a
more systematic sampling design selecting (4/13), e.g.
the first five strains of each semester, i.e. each half of
the year (Belgium), all strains of selected calendar peri-
ods (Sweden, UK-Scotland) or selected hospitals (the
Netherlands). An overview is given in the Table. A more
detailed analysis was performed by another ECDIS-
Net survey in 2011 and 2014 of diagnostic and typing
capacity for CDI in Europe: the results of which are also
reported in this issue [15].

Susceptibility testing
There were no official recommendations for routine
susceptibility testing of *C. difficile* isolates in any of
the European countries taking part in ECDIS-Net, but
susceptibility testing results were included in 7/18 CDI
surveillance systems analysed. Conditions leading to
susceptibility testing were the surveillance of antimicro-
bial resistance itself (5/7), severe CDI cases (4/7) or
outbreaks of CDI (3/7).

Discussion
This survey showed that 14 of 31 European countries
surveyed conducted some kind of CDI surveillance in
2011. The majority of the 18 existing European nation-
wide CDI surveillance systems were continuous and
prospective, and captured CDI cases by standardised
case definitions targeting the clinical symptoms of CDI
and/or laboratory diagnosis of CDI, and all of them
included CDI in hospitalised patients. However, there
were interesting differences between these systems. In
11/18 of European countries with CDI surveillance, sur-
veillance was mandatory, either by mandatory report-
ing of laboratory and/or clinically confirmed cases or
by public health notification of CDI. Whether surveil-
lance should be based on mandatory or voluntary
reporting of confirmed cases is still under discussion
[16-18]. Opponents of mandatory reporting argue that
especially in combination with public reporting of sur-
veillance results and financial penalties, it may lead to
systematic under-reporting of cases.

An important issue for surveillance purposes is the def-
inition of CDI cases. These definitions should be valid,
specific, easily understood, generally applicable and
meet the requirements of different clinical settings,
ideally across borders. Moreover, they should allow
the comparison of local, regional, national and interna-
tional infection rates [19]. The definitions proposed by
the study group for *C. difficile* of the European Society
of Clinical Microbiology and Infectious Diseases
(ESCMID) and ECDC [2] are in agreement with those
of the United States Centers for Disease Control and
Prevention (CDC) [2,14]. Most of the European CDI sur-
veillance systems adhere to these definitions, but dif-
ficulties are encountered in differentiating between
community- and healthcare-associated cases of CDI.
Some surveillance systems do not make any distinc-
tion between the two types of cases (for instance,
when only laboratory data are used), while others
use different time points for differentiating between
the two. Stratification of community-associated and
healthcare-associated CDI cases may permit recogni-
tion of changes in epidemiology, e.g. an increase in the
number of community-associated cases of CDI possibly caused by ‘hypervirulent’ C. difficile strains [1,20,21]. For feasibility reasons, the definitions of community- and healthcare-associated cases of CDI could be simplified, e.g. by adjusting the threshold time between the two types of cases to three days or later instead of 48 hours. However, regardless of the threshold used, variable proportions of CDI cases defined as community-associated CDI cases may in fact be linked to recent hospitalisation.

In order to meet the ECDC CDI case definitions, most surveillance systems used laboratory reporting and identification of CDI cases by attending healthcare personnel and/or infection control practitioners; few relied solely on laboratory test results. Only one of the Finnish surveillance systems used ICD-10 coding of CDI supplied by hospital administrations. In comparison with surveillance using CDI case definitions, surveillance using ICD coding has shown to be less sensitive [22,23]. In Finland, three different surveillance systems for CDI are run in parallel and so may compensate for their respective limitations.

All surveillance systems reporting hospital-associated CDI cases express CDI rates as incidence rate (per number of patient admissions within a given surveillance period) or incidence density (per number of patient-days). However, different orders of magnitude are used (100 or 1,000 admissions and 1,000 or 10,000 patient-days). Apart from that, surveillance systems only reporting the total number (i.e. community-associated and hospital-associated combined) of CDI cases mostly calculate the incidence per number of inhabitants; only a few exceptions just give the cumulative number of CDI cases. According to published recommendations and for better comparison, the incidence density of healthcare-associated and community-associated CDI should be expressed per 10,000 patient-days and 100,000 inhabitants, respectively [14,19].

More than half of the European CDI surveillance systems presented their findings pooled, i.e. without any further stratification. Unfortunately, only a few surveillance systems provided sender-specific analyses. This would, however, be very important to inform interventions at local level and may help to reduce infection rates [24].

Microbiological data may be an important supplement to epidemiological surveillance data and allow deeper insights into epidemiological changes. In our survey, however, strain typing and susceptibility testing were mainly restricted to outbreaks of CDI or severe cases of CDI; only a few surveillance protocols included typing or susceptibility testing on a regular basis. Although lacking the discriminatory power to study outbreaks, PCR ribotyping is the most adopted C. difficile typing methodology in European reference laboratories. International standardisation of ribotyping methods would allow comparability and reproducibility between countries. Capillary-based ribotyping offers the opportunity to achieve these aims, as results are easier to interpret and to exchange than those of conventional agarose-based ribotyping [25-27].

The main limitations of microbiological testing for C. difficile are financial, and shipment of strains to reference laboratories for typing may be hampered by the fact that many laboratories perform toxin testing alone and do not culture C. difficile.

Published recommendations of ECDC and the United States Centers for Disease Control and Prevention (CDC) are that CDI surveillance should be conducted for at least all inpatients to monitor healthcare-associated CDI, and healthcare-associated CDI rates should be expressed as number of cases per 10,000 patient-days [2,14]. A standardised European CDI surveillance protocol should be used to allow meaningful intercountry comparisons of CDI incidence rates and for follow-up of the epidemiology of CDI at European level. Special emphasis should be given to the harmonisation of definitions of community-associated and healthcare-associated CDI, inclusion criteria for patients and CDI cases, criteria for typing C. difficile strains, denominator data, epidemiological case-based data and case-finding methods. In order to integrate microbiological test results into CDI surveillance, more frequent culture of C. difficile is required, and typing methods should be standardised. Harmonised systematic surveillance at national and European level is more likely to facilitate the identification of epidemiological changes and the optimal control of CDI. As a result of this survey, ECDC published a harmonised EU/EEA-wide hospital-based CDI surveillance protocol in May 2015 [12].

Members of ECDIS-Net (national coordinators)

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Conflict of interest

Mark H Wilcox: received research work fees, and/or consulting fees and/or lecture fees from Actelion, Cubist, Astellas, Merck, Optimer, Sanofi-Pasteur, Summit, Astra-Zeneca, Cerexa, Nabrina, Novacta, Novartis, Pfizer, Corporation Roche, The Medicines Company, VH Merieux, Da Volterra, European Tissue Symposium, Basilea, and Alere (paid to the department), and a clinical trial consultancy from Durata.

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Authors’ contributions

The survey was designed by AK, DWK and PG, with support of BHB, BC, OL, JS and CW. EJK and MHW were the principle coordinators of ECDIS-Net, using support of CS from ECDC. AK and DWK performed data collection and data analysis, PG supervised data collection and data analysis. AK wrote the manuscript together with CW. All co-authors reviewed the manuscript.

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