(See page 40)

One

Q1 b) d) Food poisoning is possible, but this is too severe for the usual case. Some norovirus infections can present like this, but they are unlikely to occur as an isolated case like Thomas's. You must not rule out Clostridium difficile just because it is not a hospital infection.

Two

Q2 a) b) e) This is a typical presentation of C. difficile infection and should be considered as the most likely diagnosis. Any thought of surgery should be delayed in favour of conservative management. An adhesion as the cause should be held in the background: as he has had no history of similar symptoms since his surgery it is less likely than a C. difficile infection.

Three

Q3 a) b) c) d) e) All of these first five steps are essential to the management of C.difficile infection. Thomas should start to recover quickly as soon as renal function returns to more normal levels. Overhydration is a risk as he needs fluid infusions but is producing very little urine: the nursing staff should be aware that he may develop massive oedema. Explorative surgery is a high risk strategy and almost certainly unnecessary.

Four

Q4 a) c) d) There is little need for urgent surgical intervention unless the obstruction persists and poses a threat to life. Paralytic ileus should resolve as the infection is overcome by the combined antibacterial treatment. Mortality in C. difficile infections contracted outside hospital is much lower than that seen in hospital-acquired infections in immune compromised patients. Most home-acquired C. difficile infections are the result of the treatment of infections with antibiotics such as clindamycin, fluoroquinolones and cephalosporins. The use of clindamycin until a few days before the acute onset of diarrhoea and vomiting, and the severity of the illness, pointed to C. difficile as its most likely cause.

Thomas is doing well at home and back to his normal self. He refused the option of a faecal microbiota transplant.