**Written responses to remaining audience questions of the webinar 'Current developments in Clostridioides difficile prevention, therapy and R&D' by Benedikt Huttner, Paul Feuerstadt, Kerrie Davies and Mark Wilcox, moderated by Christian John Lillis.**
**Originally broadcast on 13 March 2026. See webinar recording here: https://revive.gardp.org/current-developments-in-clostridioides-difficile-prevention-therapy-and-rd/**

| Question asked | Response from the speakers |
|---|---|
| What is the WHO doing about the issues/challenges responsible for the lack/low CDI diagnostic and reporting in African countries? | Benedikt - One significant step has been the inclusion of Clostridioides difficile combined Glutamate Dehydrogenase antigen and toxins A and B rapid diagnostic tests (RDTs) in the 5th WHO Essential Diagnostics List. You can find more information here.<br>Ultimately, though, the main challenge is tied to broader health system and laboratory strengthening. For further details on how WHO is working to support these efforts, please refer to the "Strategic and operational framework for strengthening bacteriology and mycology diagnostic capacity" |
| I wanted to know if you are familiar with MBK-01, the first SoHO microbiota product approved under the new human-origin substances regulation in Europe. It is a freeze-dried and encapsulated faecal microbiota transplant for the treatment of Clostridioides difficile infection and it is ready for use in Spain. | Mark - Yes, I am aware of this product, but as it appears not to be available outside of Spain, I did not include in my presentation. |
| I'm surprised mAb treatments (Bezlo & AZD) are considered so highly, wouldn't it be better to target C. Difficile bloom as a source, rather than the toxins which come after the fact? | Mark - As the key mediator of CDI is believed to be toxin B, it is reasonable to target this, either to prevent recurrence or possibly for primary prevention. Proof of concept for the former was achieved with bezlotoxumab. |
| Mark - Phase III ready S-MGB-BP3 was not highlighted, nor I think the product from Crestone. What's you view on these late stage development compounds | Mark - The product from Crestone (CRS3123) was included on slide 2 of my presentation, with a citation for the phase 2 clinical trail results.<br><br>As I said in my presentation, the two antibiotics that have completed phase 2 trails have only be given to small numbers of patients (<30 in each case) and so there true potential remains uncertain. |

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| What was the product now available in Canada and how is it spelt? | Mark - I did not refer to a product that is available in Canada. Apologies but I do not know which investigational product you are referring to. |
| Why choose the cyanobacteria, also known as blue-green algae, as the expression vector of the toxin-binding protein? | Mark - LMN-201 is an oral biologic cocktail, delivered in capsules, intended for use with and following antibiotics to improve clinical outcomes for CDI. It is made with Lumen's proprietary spirulina-based GMP manufacturing system. So, the blue-green algae are used a biological production tool. |
| Mark - Any update on mRNA lipid nanoparticle vaccine? | Mark - I am not aware of any significant updates currently. |
| Kerrie - Looking at the CT for PCR. We did our investigation and found CT > 27 was more associated with colonization. What CT threshold should be used; although is not validated. | Kerrie - There are several publications on this subject now, but all have used a different threshold value, so there is no consensus on the best CT value to use. |
| Rebyota and Vowst insurance and process for obtaining in a timely manner following completion of tx has been frustrating. Need to start within 2 days of stopping tx, but often do not get drug until well after this time frame, requiring pt to continue CDI therapy. Need to advocate for a better system to have this more readily available? Openbiome was great and much easier for patient access. | Paul - The reality is that the insurance companies are dictating this and Openbiome is no longer available. So, I typically give 21-28 days of SOC antimicrobial to give lead time for approval and then will have the patient stop the antimicrobial when they receive the product for the washout. This allows flexibility. The open label studies had 10+ days of treatment, so this fits with that. Since the antimicrobial is controlling the vegetative phase of infection and we are supplementing the microbiota, the length of treatment becomes less relevant. |
| Is Feacal Transplant still the last resort intervention? | Paul - Faecal transplant is no longer last resort. According to guidelines it should be considered in everyone with second recurrence and beyond and in those patients with first recurrence who are at greatest risk for future recurrence. |
| Paul - What is the efficacy of the fecal microbiota transplantation?" | Paul - The efficacy of fecal microbiota transplant is about 78% from a meta-analysis of only open label studies (n=1176, 19 studies, Tariq et al. 2023). That is a good overall rule of thumb for efficacy following standard of care antimicrobial. |

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| Benedikt - One argument is the CDI arises in the context of antibiotic treatment and so is by definition a form of resistant infection. Would you agree with that point of view? | Benedikt - Antibiotic exposure is the key risk factor for CDI, but this is primarily because antibiotics disrupt the gut microbiota, removing colonization resistance. This creates an ecological niche in which C. difficile (either already present or newly acquired) can overgrow and produce toxins. C. difficile does not need to be resistant to the antibiotic that triggered the infection.<br>C. difficile is intrinsically resistant to many antibiotic classes (e.g. aminoglycosides, many β-lactams) because Intrinsic resistance is not usually what AMR frameworks focus on, which tend to emphasize acquired resistance, selectable, transferable mechanisms and loss of treatment options for infections caused by the organism. |
| Kerrie - Do you have a testing recommendation that would be practical for LMICs? | Kerrie - There are lots of lateral flow immune assays that have both GDH and toxin detection on one strip. These are quick to use, however it should be noted that, while the GDH part of these tests is very good, the toxin component is less sensitive than well-based versions of EIAs. In addition, as I showed on my slides, not all tests (that detect the same things) are the same, so it is always worth looking at the literature and picking the most sensitive assay that you can. |
| Mark - Among current phase 3 candidates, is there hope for a lower cost drug superior to metronidazole and vanco AND cheaper than fidaxomicin that might be appropriate for LMICs? | Mark - That goal ultimately will rest on the pricing on a new product. The choice was made to price fidaxomicin at a relatively high price point, which ultimately majorly impacted on its use. A lower price in theory could have generated higher use and so still have been commercially viable. |

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