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CORRESPONDENCE

Fidaxomicin in the Treatment of *Clostridium difficile*-Associated Diarrhoea

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We read with interest the correspondence by Greig comparing outlays for fidaxomicin for the treatment of all primary cases of *Clostridium difficile*-associated diarrhoea (CDAD), in persons aged >65 years, and for persons in receipt of concomitant antimicrobial pharmacotherapy, with mean expenditures for hospitalization for CDAD in the UK [1].

We agree with Greig that the fiscal benefits of employing fidaxomicin in the treatment of CDAD extend beyond the acquisition cost of medication, and that the potential to reduce transmission of disease will afford a more robust financial profile in favour of fidaxomicin.

Our research comparing outlays for fidaxomicin versus vancomycin for the treatment of CDAD, with an end-point of warranted price from the perspective of the US healthcare system, concluded fidaxomicin represented value for money [2]. To examine this issue, we employed the number-needed-to-treat (NNT) as derived from the registration studies with the US Food and Drug Administration (NNT = 7.1). Moreover, to discern the fiscal utility of fidaxomicin in both primary and secondary cases of CDAD, we employed the methodology developed by O'Brien et al. [3] for attribution of hospital outlays due to CDAD in secondary cases. This approach resulted in a more conservative hurdle for fidaxomicin. Finally, it should be noted that our research employed national (US) data for both primary and secondary cases of CDAD [4].

Greig is correct to note that there are limited comparative data as regards the use of vancomycin versus metronidazole in the treatment of CDAD. That said, from a policy perspective, results reported by Greig [1] and Sclar et al. [2] indicate that fidaxomicin represents a judicious fiscal choice among select populations hospitalized for CDAD.

References

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