**Fulminant Clostridium difficile Colitis: A Complication of Perioperative Antibiotic Prophylaxis**

Antibiotic prophylaxis has been previously reported in the OMS quarterly issues March 2011 and June 2013. Antibiotic prophylaxis for maxillofacial surgical wounds remains common practice. Surgeons must weigh the risks (eg. *Clostridium difficile* colitis) against the benefits before administering antibiotics for any reason and the relative risk and morbidity of *C difficile* colitis against those of a potential postoperative wound infection. In addition, the possibility of *C difficile* infection as a complication of perioperative antibiotic prophylaxis should be discussed with patients before surgery, especially those with concomitant baseline risk factors. This report describes the case of a young healthy patient with few risk factors for *C difficile* infection who received a standard perioperative course of antibiotic therapy. Subsequently, the patient developed severe fulminant *C difficile* infection that required a protracted hospital admission, subtotal colectomy, and ileostomy. This case underscores that antibiotic prophylaxis continues in widespread use and is not benign therapy.

A 19-year-old woman was referred by her orthodontist for evaluation and correction of dentofacial deformity. She reported a 5-year history of tetracycline 500mg by mouth twice daily for acne. This was completed without complication 6 months before her presurgical history and physical. She was scheduled for Le Fort I maxillary advancement with impaction and extraction of her impacted mandibular third molars. The patient received a preoperative dose of cefazolin 1,000 mg intravenously, which was continued every 8 hours postoperatively. The surgery was uneventful. On postoperative day 8, the patient presented to the emergency department with complaints of nausea, emesis, diarrhea, and rectal pain. She was noted

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**Dental Fun Fact**

**Did You Know...**

The average human produces 25,000 quarts of saliva in a lifetime. That’s enough spit to fill up 2 swimming pools! (http://brynmawr.patch.com/blogs/david-m-dillondmds-blog)
to have an unsteady gait, appeared distressed, but with stable vital signs. She received flexible sigmoidoscopy, colectomy (surgical resection of the large intestine), ileostomy (surgical opening to bring intestine to surface of skin), and rectopexy (surgical placement and securing of rectum). Six months later, she was treated with ileorectal anastomosis and colostomy closure, without complications.

In conclusion, antibiotic prophylaxis for maxillofacial surgical wounds remains common practice in most hospitals. Surgeons must weigh the risks against the benefits before administering antibiotics for any reason, and the possibility of C difficile colitis lurks among the risks.

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Dr. Brian Simpson announces the eighteenth meeting of the
NANUET IMPLANT STUDY GROUP

Speaker: Dharti Patel, DMD, FDSRCS(Ed), FICOI
Diplomate American Board of Oral Medicine
Diplomate American Board of Orofacial Pain
Clinical Assistant Professor, NYU College of Dentistry

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Thursday, March 13, 2014
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-Walt “Clyde” Fraizer