RICHMOND
ENDODONTIC CENTRE

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Difficile avec Clindamycin

All antibiotics run the risk of causing a Clostridoides difficile (C.diff.) infection, formerly known as Clostridium difficile. Even a single dose for premedication puts one at risk. C. diff. is a bacterium that causes severe, prolonged, and potentially life-threatening diarrhoea and colitis. Since 2010, the incidence of this sepulchral defilement has significantly increased in conjunction with the emergence of substantially more virulent strains. In 2011, C. diff. was responsible for approximately half a million infections and associated with just under thirty thousand deaths in the USA.

Antibiotic use is the single-most-important modifiable risk factor for a C. diff. infection. Compared to all other antibiotics, clindamycin is more than four times as likely to precipitate such infections. Mounting evidence has led multiple American medical and dental governing bodies to no longer recommend the use of clindamycin. azithromycin, cephalexin, or clarithromycin have replaced it in their official guidelines. If a person cannot take one of these antibiotics and the other two are inappropriate then clindamycin may be considered.

Rampant diarrhoea or an unsettled stomach is not indicative of an allergic reaction to penicillin. For those that are penicillin-intolerant, cephalexin is worth considering. A true penicillin allergy involves a definitive history of anaphylaxis, angioedema or hives. For these people, the primary antibiotic recommendation is now azithromycin, not clindamycin.

Another development is that antibiotic use is to be discontinued as soon as decisive treatment (i.e. endodontic treatment or extraction) and symptom abatement is realised. No longer is taking the full course of the prescription written in stone. If timely treatment is provided and rapid elimination of symptoms occurs then antibiotic use can be halted even after a mere few days.

When warranted for an odontogenic infection, amoxicillin and other beta-lactam-based antibiotics remain the exemplar prescription recommendation. If the infection has not responded favourably to the prescribed antibiotic, then add metronidazole to complement the current regimen. One should be judicious in the use of antibiotics as prompt treatment is effective and there is a litany of drawbacks to their use including, but not limited to, nausea, vomiting, diarrhoea, stomach cramps, C. diff. infection, yeast infections, allergic reactions (i.e. rash, skin reactions, Stevens-Johnson syndrome, breathing difficulty, and anaphylaxis), and the development of multidrug-resistant bacteria. For a healthy person, if there is no evidence of lymphadenopathy, fever, malaise, fascial space involvement, an antibiotic prescription need not accompany expeditious endodontic treatment of a tooth with pulpitis, or pulp necrosis with symptomatic apical periodontitis or localised acute apical abscess.

Eliminating odontogenic infections and protecting the health of our patients need not be très difficile. Be punctilious by prescribing azithromycin instead of clindamycin, provide timely and unambiguous treatment, consider adding metronidazole if an infection proves to be impervious, and resist the urge to insist a patient complete a prescription after definitive treatment and obvious surcease.

Regards,

Joel N. Fransen
BSc(OT), DMD, FRCD(C)
Certified Specialist in Endodontics

Richmond Endodontic Centre
Dr. Joel N. Fransen

110-11300 No.5 Rd
Richmond, BC V7A 5J7
office@endodonticcentre.com
T 604.274.3499
F 604.274.3477

Office Hours
8am to 5pm - Monday to Friday
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