Editorial

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Pseudomembranous colitis predominantly is a complication of modern antibiotic therapy. A variety of chronic disorders as well as surgery may contribute to its pathogenesis by disturbing the normal function of the bowel and its bacterial colonization. In 1977, Bartlett et al. [1] were able to prove that overgrowth of toxin-producing strains of the anaerobe bacterium *Clostridium difficile* causes the typical picture of this disease. Clindamycin, cephalosporins, and broad-spectrum penicillins had been found to be the main responsible agents, and the adequate medical therapy was quickly detected: vancomycin or metronidazole delivered via the oral route. This prompted Bartlett [2] in 1990 to state that 'the whole clinical setting was almost complete by 1987. We doubt that.

Diarrhea is a frequent symptom and as large is the scale of underlying diseases. The percentage of undetected cases of *C. difficile*-associated colitis may be high because of mild presentation. However, the severe cases bare the clinical problems where diagnostic and therapeutic challenges begin. Pseudomembranes are not always present, even when toxin tests are positive. The classical cell culture test for detection of the cytopathic toxin B is time-consuming, the enzyme-linked immunosorbent assay faster but less sensitive. Occasionally the disease may proceed very fast and suddenly present as a life-threatening disorder, with all forms of organ failures or with peritonitis, ileus, or colon perforation.

Medical therapy should be immediately initiated when a severe course of the disease is suspected, intensive care facilities should be available. If conditions worsen, and the plain X-ray picture shows colon dilation, endoscopic decompression may be indicated in order to prevent the development of toxic dilation, ileus, or colon perforation [3]. Surgery must be the treatment of last choice. If surgery is necessary, colectomy with ileostomy should be performed. Limited resection will usually be insufficient because of undetected disease left behind [4].

In this issue Marchena et al. [5] present a case of pseudomembranous colitis complicating ulcerative colitis. The patient was in a life-threatening condition and was cured by subtotal colectomy with Brooke's ileostomy. These authors illustrate the clinical, pathological and laboratory settings of pseudomembranous colitis in a commendable thoroughgoing fashion. By searching for parallels between ulcerative and pseudomembranous colitis, they point out the scope of this disease.

References

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