THE ACUTE ORAL/DENTAL PROBLEM

The Maxillofacial team is based in Ashford Hospital, with some clinics in St Peter's Hospital.

The secretaries are on extension 2028, and they will be able to say if there is a clinic in SPH, or there is a doctor to give advice.

Up to 17.00 the on-call SHO can be contacted on 8157 or 8158. Between 17.00 and 22.00 the on-call registrar can be contacted via switchboard. After 22.00, the on-call doctors are at Royal Surrey County Hospital in Guildford. Please ask switchboard to bleep the on call doctor rather than being put through to the ward sister, who may not be able to accept referrals.

The following conditions MUST be discussed with the Maxillofacial team:

Avulsed teeth

Dog bites to the head and neck region

Lacerations involving lips, alar margins, eyelids and ears.

Intra-oral bleeding

Facial infection

Suspected bony injuries

Trauma:

Maxillofacial bony injuries are rare in children with the exception of condylar injuries; ask the child to open the mouth, and bite down to ensure normal alignment of teeth. An orthopantomogram and/or PA mandible view can help with the diagnosis.

Dental injuries are common, with 8% of 5 year olds who have experienced dental trauma.
It is essential to ask the parents whether the teeth are permanent or deciduous (baby) teeth.

Permanent teeth erupt between 5 and 8 years old.

THE KEY TO DIAGNOSIS LIES IN RECOGNITION OF TOOTH MOVEMENT AND CHANGES IN OCCLUSION (BITE).

Lacerations:

Clean and debride

Use 4/0 or 5/0 Vicryl deep

6/0 Ethilon or PDS skin

Not all lacerations require suturing. If well approximated clean and use topical antibiotic. This includes lips.

If the vermillon is not gaping then these can often be treated conservatively. Must be seen by Maxillofacial team if in doubt.

NEVER use glue on lips

Avulsed teeth:

Wash the tooth with saline holding the tooth by the crown.

If possible reimplant the tooth - it can be temporarily held in place with thick foil, or ask the patient to bite down on layers of gauze if tinfoil not avaviable.

(Reimplantation within 1 hour of avulsion is 50% successful. Over 2hrs it is unlikely to be successful.) Contact the Maxillofacial surgeon.

If the tooth cannot be reimplanted in Accident and Emergency or is very unstable then store it in a sterile container in milk until the oral surgeon can see the patient.

An intruded tooth is one that has been pushed in apically. If the tooth is firm give antibiotics and refer to own dentist

Fractured tooth:

Check that the loose piece has not been inhaled

If the fracture enters the pulp (a visible small red clot in the centre of the tooth) contact the Maxillofacial surgeon.

If the fracture does not enter the pulp refer to own dentist.

Bleeding socket:

Local anaesthesia

Wash out the mouth and/or suction the area to identify the bleeding point

Get the patient to bit on a gauze pack for 20 mins sitting upright.

After 20 mins remove the pack gently and inspect. Resist the temptation to inspect more frequently since this just disturbs the clot.

If bleeding continues pack the socket with Surgicel or Kaltostat and get them to bite on a pack again. This will usually be effective but if it isn't you will need to contact the oral surgeon to suture the socket.

Infection:

Pulpitis

Pericoronitis

Periodontitis

Trauma

Rarely other causes – Skin, Parotid,TB etc

Facial swellings:

Assume all facial swellings are dentally caused until proved otherwise.

History of dental pain (toothache) and loss of sleep
Beware pyrexia, dysphagia and trismus

OPG screening radiograph

Haematology/Biochemistry

Consider admission for IV antibiotics/ Incision & Drainage

Antibiotic choice:

Contact microbiology, but ideally Augmentin

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Updated 28/03/2018 Dr Erin Dawson