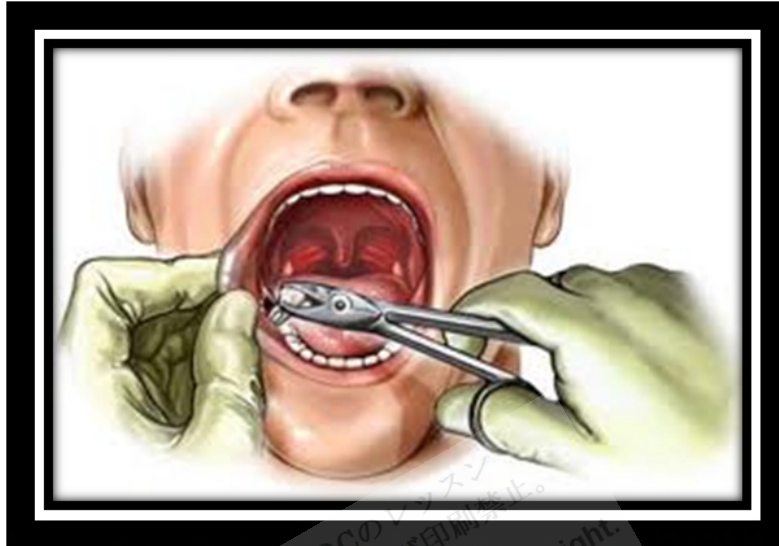


Post Extraction Problems



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Swelling and pain: Swelling is normal after oral surgery and is proportional to the degree of manipulation and trauma. An ice pack (or a plastic bag of frozen peas or corn, which adapts to **facial contours**) should be used for the first day. Cold is applied for 25-min periods every hour or 2. If swelling does not begin to subside by the 3rd **postoperative** day, infection is likely and an **antibiotic** may be given (eg, penicillin VK 500 mg po q 6 h until 72 h after symptoms subside).

Postoperative pain varies from moderate to severe and is treated with analgesics.

Alveolitis and osteomyelitis: **Postextraction alveolitis** (dry socket) is pain emanating from bare bone if the socket's clot lyses. Although assumed to be due to bacterial action, it is much more common among smokers and oral contraceptive users. It is peculiar to the removal of mandibular molars, usually wisdom teeth. Typically, the pain begins on the 2nd or 3rd postoperative day, is referred to the ear, and lasts from a few days to many weeks. **Alveolitis** is best treated with topical analgesics: a 1- to 2-in **iodoform** gauze strip saturated in **eugenol** or coated with an **anesthetic ointment**, such as **lidocaine** 2.5% or **tetracaine** 0.5%, is placed in the socket. The gauze is changed every 1 to 3 days until symptoms do not return after the gauze is

left out for a few hours. This procedure eliminates the need for systemic analgesics.

Osteomyelitis, which in rare cases is confused with **alveolitis**, is differentiated by fever, local tenderness, and swelling. If symptoms last a month, a **sequestrum**, which is diagnostic of osteomyelitis, should be sought by x-ray. **Osteomyelitis** requires long-term treatment with antibiotics effective against both **gram-positive** and **gram-negative organisms** and referral for definitive care.

Osteonecrosis of the jaw (ONJ): ONJ is an oral lesion involving persistent exposure of **mandibular** or **maxillary bone**, which usually manifests with pain, loosening of teeth, and purulent discharge. ONJ may occur after dental extraction but also may develop after **trauma** or **radiation therapy** to the head and neck. Recently, an association has been discovered between use of **antiresorptive agents** and ONJ. These agents include **bisphosphonates (BP)**, osteoclast inhibiting drugs, and **cathepsin K inhibitors**. Cancer patients receiving IV BP have a 4-fold increased risk of ONJ, perhaps due to greater **bioavailability** of IV BP. However, oral BP therapy for noncancer patients seems to pose very low risk of ONJ; the prevalence in this population is about 0.1% according to a recent estimate. Stopping oral BP therapy is unlikely to reduce this already low rate of ONJ, and maintaining good oral hygiene is a more effective preventative measure than stopping oral BP before dental procedures. Higher doses and longer duration (therapy > 2 yr) of **antiresorptive therapies** are associated with ONJ. Management of ONJ is challenging and typically involves limited debridement, antibiotics, and oral rinses.

Bleeding: **Postextraction** bleeding usually occurs in the **small vessels**. Any clots extending out of the socket are removed with gauze, and a 4-in gauze pad (folded) or a tea bag is placed over the socket. Then the patient is instructed to apply continuous pressure by biting for 1 h. The procedure may have to be repeated 2 or 3 times. Patients are told to wait at least 1 h before checking the site so as not to disrupt clot formation. They also are informed that a few drops of blood diluted in a mouth full of saliva appear to be more blood than is actually present. If bleeding continues, the site may be **anesthetized** by nerve block or local infiltration with 2% **lidocaine**

containing 1:100,000 **epinephrine**. The socket is then curetted to remove the existing clot and to freshen the bone and is irrigated with normal saline. Then the area is sutured under gentle tension. Local hemostatic agents, such as **oxidized cellulose**, topical **thrombin** on a gelatin sponge, or **microfibrillar collagen**, may be placed in the socket before suturing.

If possible, patients taking low-dose **anticoagulants** (eg, **aspirin**, **clopidigrol**, **warfarin**) should stop therapy 3 to 4 days before surgery. Therapy can be reinstated that evening. If these measures fail, a systemic cause (eg, **bleeding diathesis**) is sought.

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