

# Triaging dental presentations for medical practitioners

Patients with dental problems commonly present initially to a medical practitioner. The medical practitioner should usually redirect these patients to a dentist, particularly if the presentation relates to previous dental treatment (eg complications after tooth extraction). However, medical practitioners often provide acute care for dental problems, particularly in the rural or remote setting—see [Table 13.27](#).

## Common dental problems encountered by medical practitioners (Table 13.27)

Presenting problem	Comments	Urgency and referral
<b>Acute dental pain</b>		
<b><a href="#">acute dental pain</a> with or without facial swelling</b>	antibiotics are rarely indicated analgesics may be indicated  for a guide to differentiating acute dental pain, see <a href="#">Table 13.12</a>	urgency and referral are dependent on the diagnosis
<b>Conditions presenting after an oral or dental procedure</b>		
<b><a href="#">bleeding after oral surgery</a> (eg tooth extraction)</b>	check anticoagulant status manage with direct pressure and local haemostatic measures	if bleeding is not controlled, emergency referral to hospital or oral surgeon

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Presenting problem	Comments	Urgency and referral
<b><u>pain and swelling after oral surgery</u></b> (eg tooth extraction)	pain and swelling usually peaks 48 to 72 hours after surgery, before it starts to resolve  antibiotics are rarely indicated	referral to or consultation with practitioner who performed the oral surgery (within 24 hours)
<b>prolonged numbness (anaesthesia) or altered sensation in the mouth (paraesthesia) after a dental procedure</b>	can be caused by nerve trauma or local anaesthetic neurotoxicity	referral to or consultation with practitioner who performed the procedure (within 24 hours)
<b>Dental and maxillofacial trauma</b>		
<b><u>broken tooth or filling, or lost filling</u></b> (or other restoration)	assess whether dentine or pulp has been exposed  antibiotics are not indicated	without pain, nonurgent referral to dentist (within a few days)  with pain, urgent referral to dentist (within 24 hours)
<b><u>tooth avulsion (knocked-out tooth)</u></b>	requires urgent assessment  primary teeth (baby teeth) must not be replanted	for a secondary tooth, urgent referral to dentist  for a primary tooth, nonurgent referral to dentist
<b><u>maxillofacial trauma, deranged occlusion (teeth not biting together normally)</u></b>	address any life-threatening complications immediately  all patients require thorough assessment	for patients with significant trauma, emergency referral to hospital

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Presenting problem	Comments	Urgency and referral
<b>Conditions affecting the gums</b>		
<b>bleeding gums caused by minor trauma (eg eating, cleaning teeth)</b>	<p>in children, commonly due to <a href="#">exfoliating teeth</a></p> <p>in adults, commonly due to <a href="#">gingivitis</a> or <a href="#">periodontitis</a></p>	for adults, referral to dentist or periodontist (urgency dependent on severity)
<b>spontaneously bleeding gums</b>	<p>with pain, halitosis, necrosis or ulceration of the interdental papillae, the likely cause is <a href="#">necrotising gingivitis</a></p> <p>consider drugs that affect haemostasis, acquired or congenital bleeding disorders, or other haematological disorders</p>	necrotising gingivitis requires urgent referral to dentist
<b>swollen, puffy or enlarged gums (gingival hyperplasia), with or without bleeding</b>	<p>consider adverse effects of drug (eg calcium channel blockers, phenytoin, ciclosporin); encourage improved <a href="#">oral hygiene</a></p> <p>in the absence of drug causation, consider possible malignancy</p>	nonurgent referral to dentist if review required
<b>swollen, painful or bleeding gums around a dental implant, or a loose or broken implant</b>	see <a href="#">Peri-implant diseases</a>	referral to dentist who placed the implant (urgency dependent on severity)

Presenting problem	Comments	Urgency and referral
<b>sore areas beneath dentures</b>	<p>remove denture and examine the mouth and denture, consider <a href="#">denture hygiene</a></p> <p>consider trauma from an ill-fitting denture—it may need adjustment</p> <p>consider oral candidiasis or denture-associated erythematous stomatitis (see <a href="#">Table 13.11</a>)</p> <p>consider possible malignancy—any suspicious lesions or pigmentation require investigation, see <a href="#">Assessment of oral mucosal disease</a></p>	nonurgent referral to dentist (within a few weeks) if dental review required
<b>Conditions affecting the jaw</b>		
<b>jaw clicking or locking with acute unilateral or bilateral pre-auricular pain</b>	<p>jaw clicking without pain, discomfort or trismus is normal—referral is not needed</p> <p>consider <a href="#">temporomandibular disorders</a></p>	referral to oral medicine specialist or oral and maxillofacial surgeon (urgency dependent on severity)
<b>restricted mouth opening (<a href="#">trismus</a>)</b>	<p>consider tetanus and dystonic reactions, including drug-related dystonic reactions (eg metoclopramide)</p> <p>oral and dental causes include <a href="#">infection</a>, procedural complications (eg haematoma), partially erupted wisdom tooth or <a href="#">temporomandibular disorders</a></p>	if medical causes excluded, urgent referral to dentist (within 24 hours)
<b>Other oral presentations</b>		

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Presenting problem	Comments	Urgency and referral
oral malodour ( <b>halitosis</b> )	commonly caused by oral conditions, but may be a symptom of systemic disease	if medical causes excluded, referral to dentist (urgency dependent on likely intraoral cause)
acute onset of numbness (anaesthesia), altered sensation (paraesthesia) or weakness in the mouth	consider malignancy, multiple sclerosis	urgent referral for medical investigation

# Approach to managing acute odontogenic infections

An acute odontogenic infection requires prompt management with dental treatment (eg extraction, root canal) or surgical intervention, to address the source of the infection. Antibiotic therapy is not a substitute for dental treatment, but may be required if dental treatment is not likely to be received within 24 hours. Whether the patient can be managed in the community or requires hospital admission depends on the severity of the infection (see [Table 13.9](#)).

Seek expert advice for patients with recurrent infection who have received antibiotics but not dental treatment.

Antibiotic therapy is not a substitute for dental treatment of odontogenic infection.

Odontogenic infection is usually polymicrobial, involving anaerobic and aerobic oral bacteria. Metronidazole is used in conjunction with a penicillin because of increased rates of resistance to penicillins in some oral bacteria (eg *Prevotella oralis*). However, amoxicillin+clavulanate has adequate anaerobic activity, so can be used as a single preparation.

## Acute odontogenic infections: features and overview of management (Table 13.9)

[Printable table](#)

	Clinical features	Management overview
<b><u>localised odontogenic infection</u></b>	dental pain abscess (localised swelling on the gum or fluctuant tissue) pus may be visible no facial swelling no severe or systemic features of infection	outpatient dental treatment if dental treatment is not likely to be received within 24 hours, medical practitioners can start antibiotic therapy; however, ensure the patient receives dental treatment

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	Clinical features	Management overview
<u><a href="#">spreading odontogenic infection without severe or systemic features</a></u>	<ul style="list-style-type: none"> <li>facial swelling</li> <li>dental or facial pain</li> <li>abscess (localised swelling on the gum or fluctuant tissue)</li> <li>pus may be visible</li> <li>no severe or systemic features of infection</li> </ul>	<ul style="list-style-type: none"> <li>outpatient dental treatment followed by oral antibiotic therapy</li> <li>if dental treatment is not likely to be received within 24 hours, medical practitioners can start antibiotic therapy; however, ensure the patient receives dental treatment</li> </ul>
<u><a href="#">spreading odontogenic infection with severe or systemic features</a></u>	<ul style="list-style-type: none"> <li><b>severe features</b> such as significant facial swelling and pain, trismus, neck swelling, difficulty swallowing, difficulty breathing or airway compromise</li> <li><b>systemic features</b> such as pallor, sweating, tachycardia, an axillary temperature above 38°C [NB1] or sepsis</li> </ul>	<ul style="list-style-type: none"> <li>provide appropriate support of airway, breathing and circulation</li> <li>urgent transfer to a hospital with an oral and maxillofacial surgeon or other appropriate expert</li> <li>surgical intervention and intravenous antibiotic therapy</li> </ul>

NB1: Oral temperatures are unreliable for infections originating in the mouth.

For antibiotic therapy of spreading odontogenic infections without systemic or severe features, use:

- 1 metronidazole 400 mg (child: 10 mg/kg up to 400 mg) orally, 12-hourly for 5 days

PLUS EITHER

- 1 phenoxymethylpenicillin 500 mg (child: 12.5 mg/kg up to 500 mg) orally, 6-hourly for 5 days

OR

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2 amoxicillin 500 mg (child: 15 mg/kg up to 500 mg) orally, 8-hourly for 5 days

OR (as a single preparation)

2 amoxicillin+clavulanate 875+125 mg (child 2 months or older: 22.5+3.2 mg/kg up to 875+125 mg) orally, 12-hourly for 5 days.

For patients **hypersensitive to penicillins**, use:

clindamycin 300 mg (child: 7.5 mg/kg up to 300 mg) orally, 8-hourly for 5 days [\[Note 1\]](#).

Review the patient 48 to 72 hours after starting treatment to check response. Advise the patient to seek prompt dental review if their condition deteriorates or if the infection has not resolved within 5 days.

Review patients within 48 to 72 hours of starting treatment.

# Analgesic regimens for severe acute dental pain in adults

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For factors that affect the choice of analgesic regimen, see [here](#).

Nonopioid analgesics (NSAIDs and paracetamol) should be taken regularly, rather than as required, to achieve continuous pain relief.

For **severe acute nociceptive dental pain** (eg after dental surgery) in patients who can use NSAIDs, as a three-drug regimen, consider:

ibuprofen 400 mg orally, 6- to 8-hourly for the shortest duration possible and no more than 5 days without review

OR (if a COX-2-selective NSAID is preferred based on the patient's risk factors [see [Nonsteroidal anti-inflammatory drug use in dentistry](#)])

celecoxib 100 mg orally, twice daily for the shortest duration possible and no more than 5 days without review

## PLUS

paracetamol 1000 mg orally, 4- to 6-hourly (to a maximum of 4 g in 24 hours) for the shortest duration possible

## PLUS

oxycodone immediate-release 5 mg orally, every 4 to 6 hours as necessary, for the shortest duration possible and no more than 3 days. Use a lower dose in elderly or frail patients because they are particularly vulnerable to adverse effects. Prescribe small quantities (eg 10 tablets) to avoid inappropriate use in the community.

In patients who cannot use NSAIDs, use paracetamol plus oxycodone.

Always consider the benefits, harms and regulatory requirements of prescribing an opioid (see [Opioid use in dentistry](#)). Prescribe the lowest effective dose, and advise patients to take a dose only when necessary. Ensure the patient understands the intended duration of opioid use and when to stop taking the opioid or return for review (eg if pain persists for longer than expected). This is of particular importance because long-term opioid use often starts with the use

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of opioids to treat acute pain. As the tissue heals and the patient requires less analgesia, use a stepwise approach to tapering and stopping analgesics. First, stop oxycodone, then stop ibuprofen or celecoxib, and lastly, stop paracetamol.

Ensure patients understand the intended duration of opioid use.

For patients currently taking opioids for another indication, consult their medical practitioner to determine an appropriate analgesic regimen; specialist pain management advice may be required if the patient is opioid-dependent.

If opioids have not been required in hospital or pain can be successfully managed with nonopioid analgesia, do not prescribe opioids on discharge. Do not use modified-release opioids for acute dental pain.

Administering local anaesthetics by infiltration or regional block is an alternative or additional strategy for the management of severe acute dental pain, provided the clinician is competent in these methods (see [General information about local anaesthetics in dentistry](#)).

If analgesics are used after a surgical procedure that causes postoperative pain, inform the patient of the usual course of pain (eg pain is worst 48 to 72 hours after surgery, then improves). Advise the patient to return to the dentist for review if pain persists.

If postoperative pain persists for longer than expected, advise patients to return to the dentist for review.