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Oral Surgery in Unprecedented Times for the General Practitioner

The management of dento-alveolar infection is now complicated by the presence of the highly infective COVID-19 virus. It is reasonable now to assume that all our patients can be carriers of the virus. This put extra demands on personal protection for all the staff involved.

The patients who present with <u>pain</u> and <u>an infection</u>, must be treated. There will be increased usage of antibiotics in lieu of active surgery. In many ways this goes against the primary method of treatment being that the removal of the source of infection. We know that antibiotics can stall the progress of odontogenic infection. The use of antibiotics is usually associated with surgical intervention, but this now has to be reconsidered.

The question is, when can you delay the relief of acute infection by antibiotic usage alone and when is it necessary to forward the patient to specialist and/or hospital care? We recognise that the latter option incurs increasing difficulty as the hospitals are engaged in more pressing procedures. In addition, general hospitals will only do oral/maxilla-facial patients in full infectious disease personal protection cover. This includes of negative air pressure surgical sites. It is only reasonable when reading the above that we will have to stall as much as possible.

The danger signs that we all recognise for the spreading of infection which can become life threatening are now more important than ever to be recognised. The combination of trismus and dysphagia, with or without, elevated temperature is a paramount sign of progress towards airway obstruction. Such a patient will normally have swelling (which is indicative of infection spreading from its dental source). These patients must be sent to a hospital.

In the absence of trismus or dysphagia, aggressive antibiotic therapy can be utilised. Radiographic examination is mandatory so that one can confirm that the infection is of dental origin. Augmentin is the preferred antibiotic because Penicillin alone is unlikely to provide clinical improvement. Should the patient be allergic to Penicillin based drugs, Clindamycin is the alternative.

Ibuprofen coupled with Paracetamol (400mg/1gm, 8-hourly, 3 days) is recommended for immediate interim analgesia. The patient ought to be assessed within 24 hours. Telephone communication may not be sufficient and any deterioration of a patient by malaise is best determined by face to face consultation. It is not considered adequate patient care to issue antibiotics and to review at the patient's discretion.