Suspected dental infections in primary care (outside dental settings)

Patients presenting to non-dental primary care services with dental problems should be directed to their regular dentist or, if this is not possible, to the NHS 111 service (in England) who will be able to provide details of how to access emergency dental care. In Cheshire and Merseyside there is an also an emergency dental helpline (0161 476 9651) which operates from 9.00 am to 9.30 pm every day including weekends and Bank Holidays.

Note: antibiotics do not cure toothache. First line treatment is with paracetamol or ibuprofen, or both. Codeine has no proven efficacy for toothache.

PHE (2019). Patient information leaflet: antibiotics don't cure toothache.

Abscess, dental

Antibiotics are not appropriate in cases where the infection is localised to the peri-radicular tissues as this indicates that the infection is being adequately managed by the immune system. In these cases, the abscess is mostly isolated from the circulation, resulting in very little antibiotic penetration.

Regular analgesia dosed appropriately should be advised until a dentist can be seen for urgent drainage.

Antibiotics are only required if immediate drainage is not achieved using local measures or in cases of spreading infection (swelling, cellulitis, lymph node involvement) or systemic involvement (fever, malaise) or a high risk of complications.

Patients with severe odontogenic infections (cellulitis, plus signs of sepsis; difficulty in swallowing; impending airway obstruction] should be referred urgently for hospital admission to protect airway, for surgical drainage and for IV antibiotics.

Last updated: Dec 2019

If antibiotics are indicated: amoxicillin 500 mg TDS for up to 5 days. Review at 3 days. Doses can be doubled in severe infection.

Penicillin allergy: clarithromycin 500 mg BD for up to 5 days. Review at 3 days.

If spreading infection (lymph node involvement or systemic signs, that is, fever or malaise): add metronidazole 400 mg TDS for up to 5 days, review at 3 days.

Mucosal ulceration and inflammation (simple gingivitis)

There are no indications for the prescribing of systemic antimicrobials for the management of gingivitis.

The primary cause for mucosal ulceration or inflammation (aphthous ulcers; oral lichen planus; herpes simplex infection; oral cancer) needs to be evaluated and treated.

Superficial infections of the mouth are often helped by warm mouthwashes which have a mechanical cleansing effect and cause some local hyperaemia. However, to be effective, they must be used frequently and vigorously.

Last updated: Dec 2019

First line: simple saline mouthwash PRN (half a teaspoon of salt dissolved in a glass of warm water) **or**

chlorhexidine gluconate 0.2% mouthwash, rinse or gargle with 10ml BD for 1 minute (do not use within 30 minutes of toothpaste) **or**

hydrogen peroxide 6% solution, dilute 15 ml in half a glass of warm water and rinse or gargle 2-3 times a day for 2-3 minutes.

Always spit out mouthwashes after use. Use until lesions resolve or less pain allows for oral hygiene. Reversible discoloration of teeth and tongue may occur with chlorhexidine mouthwash.

Necrotising ulcerative gingivitis, acute

Refer to dentist for scaling and hygiene advice.

Prescribe a mouthwash for plaque control.

Only commence metronidazole if there are systemic signs and symptoms.

Last updated: Dec 2019

First line: chlorhexidine gluconate 0.2% mouthwash, rinse or gargle with 10 ml BD for 1 minute (do not use within 30 minutes of toothpaste) **or**

hydrogen peroxide 6% solution, dilute 15ml in half a glass of warm water and rinse or gargle 2-3 times a day for 2-3 minutes.

Always spit out mouthwashes after use. Use until pain allows for oral hygiene. Reversible discoloration of teeth and tongue may occur with Chlorhexidine Mouthwash.

If antibiotics are indicated: metronidazole 400 mg TDS for 3 days.

Pericoronitis (soft tissues surrounding the crown of a partially erupted tooth)

Refer to dentist for irrigation and debridement.

Use antiseptic mouthwash if pain and trismus limit oral hygiene.

If severe local swelling, systemic symptoms or trismus, prescribe antibiotics.

Last updated: Dec 2019

First line: chlorhexidine gluconate 0.2% mouthwash, rinse or gargle with 10 ml BD for 1 minute (do not use within 30 minutes of toothpaste) **or**

hydrogen peroxide 6% solution, dilute 15 ml in half a glass of warm water and rinse or gargle 2-3 times a day for 2-3 minutes.

Always spit mouthwashes out after use. Use until pain allows for oral hygiene.

If antibiotics are indicated: metronidazole 400 mg TDS for 3 days **or** *if metronidazole can't be used*, amoxicillin 500 mg TDS for 3 days.

Prophylaxis against endocarditis

Antibiotic prophylaxis against infective endocarditis is not recommended routinely for people undergoing dental procedures. (NICE CG64, SDCEP, FGDP).

Chlorhexidine mouthwash should not be offered as prophylaxis against infective endocarditis to people at risk of infective endocarditis undergoing dental procedures.

Any episodes of infection in people at risk of infective endocarditis should be investigated and treated promptly to reduce the risk of endocarditis developing. [NICE CG64]

SDCEP (2018). Antibiotic Prophylaxis Against Infective Endocarditis.

Last updated: Dec 2019

The vast majority of patients at increased risk of infective endocarditis will not be prescribed prophylaxis as per NICE CG64. However, for a very small number of patients, it may be prudent to consider antibiotic prophylaxis (non-routine management), in consultation with the patient and their cardiologist or cardiac surgeon.

Note: GPs would not routinely be involved in this decision or asked to prescribe. This responsibility lies with the dental practitioner.