# *Endodontic Spotlight*

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*Spring 2020*

## *Spotlight on Pharmacological Management of Emergency Patients*

Introduction

With Governor's Inslee mandate for dental offices to suspend normal operations to preserve PPE and only see urgent/emergent cases, dentists have been faced with difficult decisions on the management of patient who call for our assistance. Here I will discuss some pharmacological strategies that can be performed without the use of PPE. This will not attempt to address the debate on what constitutes an emergency requiring immediate care, but rather how I would manage a patient that I have decided does not need immediate clinical treatment.

**If you are a patient, do not follow these instructions. You should contact your dentist or health care provider to determine an appropriate treatment plan. This advice is directed toward licensed providers and does not constitute a recommendation for any treatment.**

This protocol assumes a healthy patient with no contraindications. Please evaluate your patient's health history before prescribing anything. This is my personal plan. I am not recommending you follow it. Any clinical decisions you make are yours alone and I take no responsibility whatsoever for your actions.

Protocol

This protocol uses a combination of pain management medications that can be increased in a stepwise fashion as necessary. It also employs antibiotics as necessary if swelling is present. Finally physical management is added.

Pain Medications

1. Ibuprofen 600 mg qid. This is our first choice drug if the patient has no contraindications due to the anti-inflammatory properties. Healthy patients can go up to 800 mg qid (=3200 mg in 24 hours) though generally not necessary.
2. APAP 500 mg qid. In extreme cases, stagger doses with ibuprofen (i.e. ibuprofen 600 mg at 0000 hours, APAP 500 mg at 0300 hours, ibuprofen 600 mg at 0600 hours, APAP 500 mg at 1200 hours, etc). Yes, you can probably go higher with the doses but APAP is a relatively dangerous drug at higher doses so I generally avoid it if possible
3. Hydrocodone (which I write as a hydrocodone 7.5 mg / APAP 325 mg script). I have the patient take this instead of APAP (i.e. one tab qid). Again, you could probably increase the dosage but I like to keep APAP lower if possible.
    a. Some of the local pharmacies that I have called will allow you (the doctor) to drop off a signed prescription and then the patient can come in later and fill it.
4. I personally avoid steroids. Although they have great anti-inflammatory properties, they can weaken the immune system and I would rather keep the immune system stronger and manage pain with other anti-inflammatories (i.e. NSAIDs).

Antibiotics

1. General notes: Theoretically antibiotics are only indicated for localized or systemic acute apical abscess that are not able to receive dental care. (i.e. NOT for irreversible pulpitis, or pulp necrosis with just symptomatic apical periodontitis.) However, antibiotics can provide a psychological relief and could be considered for that purpose, or reduce a future swelling if you think the tooth will go necrotic soon.
2. Amoxicillin 500 mg tid. Obviously the tid will be annoying with juggled with the qid of pain meds but is generally considered the first choice now based on the recent JADA article.
3. Penicillin 500 mg qid. Also recommended though slightly less preferred now based on newest guidelines.
4. Clindamycin 300 mg qid, if allergies are present to the above. Yes, this is a high dose. However, with antibiotics, my philosophy is go big or don't do it at all.
5. Remind the patient that antibiotics may take 24-48 hours or more to be effective.
6. Given that we may be managing this infection for an extended period of time, I would give a normal prescription to knock the infection down first. I would stop the prescription and only re-prescribe if it flared back up again. (i.e. Not have them take it continuously for the duration of the mandated shut down.)

Physical Management

1. External ice: 10 minutes on / 10 minutes off. This is designed to reduce swelling and provide some pain relief given inflammation and swelling that may be present. DO NOT put heat on the outside as that may increase swelling.
2. Hot water holds: 10 minutes every hour or as much as they can. Warm water theoretically should increase circulation (and thus the immune system and antibiotic) around the area. It also can allow the infection to point, pop, and drain. Getting drainage is a great outcome for this situation, and hopefully it a transition into a sinus tract (i.e. chronic apical abscess instead of an acute apical abscess).
3. Explain the situation to the patient – they realize our hospitals are stressed and people are dying, and they want to help out society out too. Make sure the patient knows that you are available to them if things get worse.

## Conclusions

This coronavirus pandemic has strained not only dentistry but society in general, and dentists like everyone else have faced hard choices. Although my preference has always been to treat any symptomatic patient as soon as possible, at the start of this crisis we made the difficult decision to not only comply with the letter of the law but also the spirit of the mandate, and thus have managed countless of patients pharmacologically without needing to acquire additional PPE. I am thankful that our patients have been understanding of the situation and willing to give these protocols the time necessary to be effective. We are all in this together. I look forward to the day that we can safely return to scheduling patients normally again.

Endodontic Spotlight is published quarterly by Steven C. Kwan, D.D.S., M.S.D.
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