Guide to Oral Health Care for People Living with HIV/AIDS

Introduction to Oral Health: Oral Screening and Dental Management
Introduction

- HRSA/HAB sponsored curriculum designed to assist primary care providers to recognize and manage oral health and disease for people living with HIV/AIDS.

- Benefits of oral health integration in primary care:
  - Improve earlier linkage to oral health care
  - Reduce avoidable complications including oral-systemic
  - Reduce burden/costs of preventable diseases
  - Improve OH literacy of health care professionals and public

- Webcasts on TARGET Center: (https://careacttarget.org)
Guide to Oral Health Care for People Living with HIV/AIDS

Chapter 1: Oral Health
Chapter 1:

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Chapter 1: Oral Health

- **Educational Objectives**
  - Answer the question “What is oral health?”
  - Discuss the importance of oral health
  - Review the burden of oral disease
  - Recognize the appearance of healthy normal oral anatomy and common variants of normal
  - Learn a systematic approach to an efficient oral screening technique
Goals of Oral Screening in the Primary Care Setting

• Assess the oral cavity for the presence of diseases
  – Dental caries and periodontal diseases
  – Mucosal diseases
  – Oral and oropharyngeal cancers
  – Acute infections

• Enhance access to oral health care
  – Prompt referral for management of acute care needs and pathology
  – Referral for prevention and maintenance of oral health
  – Facilitate communication between the medical and dental team
  – Promote patient oral health literacy
  – Recognize importance of oral health to overall health
  – Encourage prevention and self-care
What is Oral Health?

- The health of the mouth and craniofacial (skull and face) structures.
- Freedom from oral and craniofacial diseases and conditions such as:
  - Dental caries
  - Periodontal diseases
  - Cleft lip and palate
  - Oral and facial pain
  - Oral and oropharyngeal cancers
- Among patients with HIV/AIDS, freedom from other oral mucosal disease, such as oral candidiasis, herpetic ulcers, oral warts, and salivary gland disorders.
Importance of Oral Health

• “While good oral health is important to the well-being of all population groups, it is especially critical for people living with HIV/AIDS (PLWHA). Inadequate oral health care can undermine HIV treatment and diminish quality of life, yet many individuals living with HIV are not receiving the necessary oral health care that would optimize their treatment.”

-U.S. Public Health Service Surgeon General Regina M. Benjamin, MD, MBA
Importance of Oral Health

• Good oral health:
  ✓ Improves our ability to perform functions that represent the very essence of our humanity:
    • Speak and smile
    • Smell and taste
    • Touch and kiss
    • Chew and swallow
    • Make facial expressions to show feelings and emotions
  ✓ Allows us to avoid pain and disability caused by oral diseases
  ✓ Provides protection against microbial infections and environmental insults
Burden of Oral Disease

- **Dental Caries**
  - 32% of US adults with ≤ high school education have untreated dental caries

- **Periodontal Disease**
  - 47% of US adults ≥ 30 years have mild to severe periodontitis

- **Mucosal Disease**
  - 36% of HIV-infected adults on HAART experienced ≥ 1 oral lesion over 2 years follow-up
  - 41,380 new oral and pharyngeal cancers expected in 2013

- **Disorders of the Craniofacial Complex**

- **Impact of oral diseases:**
  - Jeopardizes general health and increases morbidity and mortality
  - Restricts activity in school, work and home
  - Significantly diminishes quality of life
  - Creates an economic burden for individual, family and society
Elements of the Mouth

- Teeth, gingiva and supporting connective tissues, ligaments and bone
- Hard and soft palate
- Soft mucosal tissue lining the mouth and throat
- Tongue
- Lips
- Muscles of mastication
- Salivary glands
- Upper and lower jaws connected with the skull by the temporomandibular joint
Extraoral and Intraoral Examination

• Extraoral Examination
  – Inspection of face, head and neck:
    • Facial contour and symmetry
    • Changes on the skin
    • Preauricular, submandibular, anterior cervical, posterior auricular, and posterior cervical lymph nodes
    • Muscles of mastication
    • Salivary glands
    • Temporomandibular joint

• Intraoral Examination
  – Inspection of the internal mouth structures:
    • Teeth, gingiva, and supporting connective tissues, ligaments and bone
    • Hard and soft palate
    • Soft tissues lining the mouth and throat
    • Tongue
    • Lips
Oral health screening video
Systematic Approach to the Oral Screening

• Armamentarium
  – Gloves
  – Light source
    • Exam light
    • Otoscope light
    • Pen light
  – 2x2 gauze
  – Tongue depressor
    • Disposable dental mirror

• Techniques
  – Visual inspection
  – Bidigital palpation
    • Gently squeeze between thumb & forefinger
  – Compression
    • Gently press against bone with forefinger

• Allow 3-5 minutes for complete exam
Lips

- Shape, color, texture – symmetry
- Labial commissures – corners of the mouth
- Vermillion border – junction of facial skin and lip mucosa
- Wet/dry line – junction of inner and outer lip mucosa
Lips and labial mucosa

• Bidigital palpation
  – firm but pliable
  – slightly nodular
    • minor salivary glands
Labial mucosa and vestibule

- Labial frena
  - maxillary frenum
  - mandibular frenum

- Reflect lips
  - smooth, glistening, moist
  - vascular
Mucogingival junction

- Keratinized tissue, often “bound” to bone and less vascular in appearance in healthy tissue
  - Gingiva
  - Hard palate

- Non-keratinized tissue, “non-bound” to bone and more vascular in appearance
  - Buccal mucosa
  - Soft palate
  - Floor of mouth
Buccal mucosa

- Color, texture
  - pink, smooth, moist
Buccal mucosa and vestibule

- Parotid gland
  - palpate to check for
    - tenderness
    - firm nodules

- Stensen’s duct
  - opposite maxillary 2nd molar
  - gently depress to check salivary flow
Palatal mucosa

- **Hard palate**
  - pink, firm
  - thick keratinized tissue
  - pinpoint red macules
    - minor salivary glands

- **Soft palate**
  - pinkish-orange, movable
  - thin non-keratinized tissue
Anterior palatal mucosa

• Rugae
  – firm ridges in anterior hard palate

• Incisive papilla
  – between maxillary central incisors
Dorsal tongue

- Median lingual sulcus
- Covered with papillae
- Consistently firm and pliable
Ventral & lateral tongue

• **Ventral**
  – very thin mucosa
  – lingual veins (a)
  – lingual frenum (b)

• **Lateral**
  – note normal vertical “striped” appearance along border
Floor of mouth

- Very thin mucosa
- Lingual frenum
- Lingual caruncles
  - Wharton’s duct
    - Submandibular glands
  - Duct of Bartholin
    - Sublingual glands
Gingiva

- Pink, firm, stippled
  - knife-edged margins
    - gingiva lies flat against the tooth
  - pointed interdental papillae
    - fills space between teeth

- Normal physiologic melanin pigmentation
Teeth

- 32 adult permanent
  - molars, pre-molars, canines, incisors
- Variations in color
  - white, yellow, gray
- Check for
  - plaque
    - soft deposits of bacteria & food debris
  - calculus
    - hard calcified deposits of plaque and mineral salts from saliva
  - decayed, missing teeth
  - tooth mobility
Common normal variations (1)

a

b

mandibular tori

palatal torus

raphe

hairy tongue
Common lesions & normal variations

- **Mucocele (a)**
  - clear to bluish translucency
  - mucous cyst caused by rupture or obstruction of minor salivary gland duct

- **Irritation fibroma (b)**
  - pink, same as surrounding tissue
  - benign proliferation of dense fibrous tissue

- **Fordyce granules (c)**
  - yellowish-white
  - ectopic sebaceous glands
Common normal variations (2)

a. fissured or scrotal tongue (below)

b. facial surfaces (top right) and lingual surfaces (bottom right) with plaque & calculus
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Chapter 2: Dental Management
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Chapter 2: Learning Objectives

• Educational Objectives
  – Discuss oral-systemic connections in PLWHA
  – Recognize the role of the primary care clinician in promoting oral health
  – Describe the elements of effective medical-dental collaboration and effective dental referral
    • Standardized format for making referrals
    • Describe required labs needed by dental team
    • Dental management concerns of dentists (bleeding and infections)
    • Providing feedback to referring primary care provider
Oral-Systemic Connections in People Living with HIV/AIDS

• Oral health is critical for overall health and psychological well-being.

• The mouth is a mirror of health or disease.
  – Mucosa
  – Saliva

• Emerging evidence suggests both:
  – non-HIV oral pathogens may undermine HAART success, with periodontal disease exacerbating HIV viremia
  – chronic untreated HIV disease may contribute to the acceleration of age-appropriate periodontal disease
Impact of Patient Lifestyle Behaviors

- **Tobacco**
  - Lung cancers and heart disease
  - Oropharyngeal cancer, oral candidiasis, periodontal disease
  - Smoking is the major modifiable death risk factor for PLWHA

- **Alcohol**
  - Liver disease
  - Oropharyngeal cancer

- **Recreational Drugs**
  - Poor nutrition and hygiene, blood-borne infections
  - Poor oral hygiene, rampant dental caries (meth mouth)

- **Poor Dietary Habits**
  - Faster HIV disease progression
  - More dental caries and tooth loss
Antiretroviral Drug Effects on the Oral and Facial Region

• Xerostomia
  – Decreased saliva increases risk of dental caries and candida infections

• Fat redistribution
  – Facial fat wasting and parotid lipomatosis

• Taste disturbances

• Oral and perioral paresthesias
Spread of Oral Infections

• Bacteria (oral β streptococci and other species from dental abscesses or periodontal collections):
  – Spread locally, regionally or distantly for extension
    • Intraoral abscess, sinusitis, facial and periorbital cellulitis, submandibular or retropharyngeal abscess and airway compromise, or brain abscesses
  – Aspiration pneumonia
  – Bacteremia and possible distant site infection, infective endocarditis

• Fungus (Candida): oral to esophagus

• Virus (HSV, HPV): oral to genital; oral to anal
Role of the Primary Care Clinician in Promoting Oral Health

• Screening/detection of oral disease
  – History, risk assessment, examination

• Coaching for oral disease risk avoidance and promoting oral hygiene practices

• Evaluate and initially manage acute dental disease

• Referral to a dentist for acute/chronic dental disease ongoing medical, surgical, restorative or rehabilitative management

• Monitoring for disease progress or having obtained dental treatment intervention
Oral Disease Screening/Detection

- Symptomatic (may have chief complaint)
  - Toothache/mouth pain
  - Missing teeth
  - Gum bleeding
  - Growth or ulcer
  - Swellings
  - Difficulty eating or swallowing

- Asymptomatic (observed on oral exam)
  - Inflamed gums
  - White or red/purple patches or ulcers/growths
  - Blackened or broken teeth
Oral Disease Prevention

• Mechanical/Behavioral:
  – Diet control: limit sugary, sticky food and drinks
  – Tobacco avoidance and limiting alcohol use
  – Brushing teeth twice a day for 2 minutes
  – Flossing once daily
  – Brushing the top of the tongue
  – Use of a fluoride containing toothpaste
  – Avoid excessively abrasive toothpastes
  – Reserve tooth whitening until oral health is established
Dental Caries and Gingivitis Prevention

• Medications:
  – Decay prevention: fluorides
    • Prescription strength brush-on gel/paste- e.g. 1.1% NaF Prevident® gel or Prevident ® 5000 plus paste [apply small amount to brush and brush for 2 minutes once daily; spit out excess]
    • 0.4% Stannous fluoride gel (OTC but often stored under the counter)- e.g. Gel-Kam® or Flo-Gel® apply small amount to brush and brush for 2 minutes once daily; spit out excess]
    • Anticavity fluoride mouthrinses- e.g. ACT® (OTC), Fluorigard ® (OTC) [10ml rinse and spit]
    • OTC toothpaste
  – Gingivitis prevention:
    • antibacterial mouth rinses- e.g. 0.12% chlorhexidine [1/2 oz rinse and spit BID]
Elements of Effective Medical-Dental Collaborations

• Common areas
  – Medically complicated patients
  – Bleeding-prone patients
  – Patients at risk for infections
  – Anxious patients
**Guidelines for Antibiotic Prophylaxis Prior to Dental Treatment**

<table>
<thead>
<tr>
<th>Guidelines Addressing at Risk Medical Conditions</th>
<th>Recommended</th>
<th>Consider</th>
<th>Not recommended</th>
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<tbody>
<tr>
<td>Prior infective endocarditis, prosthetic heart valve, congenital heart disease (only 3 specific indications), cardiac transplantation recipients who develop cardiac valvulopathy <em>(AHA 2007)</em></td>
<td>![X]</td>
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<tr>
<td>Orthopedic implant (total joint replacements) <em>(AAOS/ADA 2013)</em></td>
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<td>Cardiovascular implantable electronic device <em>(AHA 2011)</em></td>
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<td>Nonvalvular cardiovascular devices. e.g. pacemakers, defibrillators, LVADs, ventriculoatrial shunt, peripheral vascular stents, vascular graphs including hemodialysis, coronary artery stents, venal caval filters, intracardiac or arterial patches <em>(AHA 2003)</em></td>
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Management of Bleeding For Patients on Hemostatic Agents

- **Warfarin**: For general dental procedures, no modification needed; single tooth extractions can be done with INR<3.0 with local hemostatics; for complex elective surgery, warfarin may need to be discontinued at least 24 hours in advance. A presurgical treatment INR should be obtained.

- **Low molecular weight heparins**: no need to discontinue for routine dental care; hold am dose only for surgical procedures.

- **Plavix and Aspirin**: no need to discontinue.

- **Pradaxa (Dabigatran) / Xarelto (rivaroxaban)**: no need to discontinue for routine dental care; for complex elective surgery, drug may need to be discontinued at least 24 hours in advance.

- Primary closure and use of adjunctive local hemostatic measures is recommended for surgical procedures in bleeding prone patients when possible.
Unmet Need and Barriers to Oral Care

• Barriers to oral care
  – Cost, access to dental care, fear of dental care, indifference to dental care, logistical issues such as transportation, language and cultural barriers

• Concerns about HIV status
  – disclosure/privacy, long delays before appointments and long waiting room times

• For children with HIV
  – poor interpersonal communication between dental staff and caregiver/child
  – shame/anger and family illness
  – caregiver dental fear and low prioritization of dental care
Oral Healthcare Access Barriers

- Low motivation or lack of awareness of importance of oral health
- Dental anxiety and fear
- Shortage of dentists trained and willing to treat patients with HIV/AIDS
- Lack of dental insurance coverage
- Limited financial resources
- Declining levels of adult dental Medicaid coverage
Overcoming Financial Access Limitations

- Oral Health Programs supporting dental care services for PLWHA:
  - HRSA Ryan White HIV/AIDS Program Dental Reimbursement Program to dental educational programs
  - HRSA Ryan White HIV/AIDS Program Community-Based Dental Partnership Program
  - Dental programs funded through other parts of the Ryan White HIV/AIDS Program

- Other lower cost dental care options:
  - County health department or federally qualified health center with dental clinic
  - Dental school or hospital dental residency clinic
  - Community-based free dental health clinic projects

- Other dental resources: contact state dental society
General Dentist

• Most referrals should be to a general dentist convenient to the patient.

• Role:
  – Assess risk, diagnose existing oral disease/conditions, encourage disease prevention.
  – Establish dental treatment plan in consultation with the patient and when complexities exist, consultation and/or coordination with the primary care provider.
  – Plan may involve referral of components of care to dental specialists.
  – Dental recall (recare) appointment interval of 3-12 months established.
Elements of an Effective Dental Referral

- **How** (does the referring dental office receive referrals? Fax, phone, letter, electronic. Ask and follow their format and process.)

- **Who** (patient information including age, contact information, medical information; do include HIV infection along with other medical conditions and past history of medical/surgical care)

- **Why** (for specific issue/concern such as toothache with abscess, missing teeth so can’t chew, purple lesion needing biopsy, broken teeth needing repair, bleeding gums/bad breath from periodontal disease, oral growth to r/o cancer)

- **What** (consultation only, consult and treat)

- **When** (emergency, urgency, routine)

- **Referred by**: referring primary care provider’s name and office contact information
Standardized Format for Making Dental Referrals

- Consult/evaluation only vs. dental assessment and treatment

- Patient’s and/or physician’s specific oral health concerns
  - Upcoming medical/surgical treatment

- Patient contact information
  - Name/contact for patient or legal guardian if patient is a minor or not legally competent to consent
  - Language barriers

- Patient medical history, medications, allergies, labs
  - Patient with substance use history and/or narcotic use contract should be identified
  - Patient with significant dental anxiety should be noted
Medical Information Dentists Need

- Medical history
- Medications
- Allergies
- TB skin test results
- Most recent labs
Required Labs Needed By Dental Team

• Basic HIV labs:
  – Absolute CD4 count
  – HIV RNA (viral load)

• CBC with differential

• Coags:
  – PT/INR
  – aPTT
  – If hemophiliac:
    • baseline deficient factor level (e.g., Factor VIII activity)
    • inhibitor titer (e.g., BIA)
Providing Feedback to Referring Primary Care Provider

• Dentists should work with the primary care provider to monitor HIV progression and treatment failure.

• When the dentist diagnoses new onset oral manifestations of HIV (such as oral candidiasis), the dentist should consult with the patient and, with consent, the referring primary care provider to address the health issue as a team.

• Interprofessional communication should also target engaging and retaining the patient in dental care.
Summary

• Oral and systemic health are interrelated.

• Dental management is most effective when coordinated with overall health management.

• Primary care clinicians play an important role in supporting their patients overall health including oral health.

• Dental management is affected by patient’s social and financial resources, behaviors, and dental access.
Guide to Oral Health Care for People Living with HIV/AIDS

Dental Emergencies
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Chapter 4: Learning Objectives

• For the medical team to recognize emergency dental needs vs. routine dental care

• Be able to understand when and what dental care could be started in the medical office
Course Overview

1. Assessment of oral concerns presenting in any medical practice

2. Review of treatment options in the medical office
   - Patient education
   - Use of analgesics
   - Use of antibiotics
   - Referral

3. Discussion and case presentations of dental emergencies requiring rapid referral to an emergency room

4. Discussion and case presentations of dental emergencies requiring referral to a dentist and an appropriate time frame for that referral
Triage Levels for Referrals

- Routine (2-4 weeks)
- Urgent (24-48 hours)
- Emergency (Same day)
Routine Dental Referral (2-4 weeks)

Teeth:
• Bothersome for several days, weeks, months
• Discomfort is mild, not disruptive to routine
• OTC meds will relieve pain
• Pain is not spontaneous, may start after eating sweet foods, cold fluids; Does not persist

Gingiva/Periodontal:
• Plaque, calculus
• Mildly inflamed gingiva visible
• Mild pain or discomfort
Urgent Referral 2 days (1)

Teeth:

• Pain is severe, disruptive to daily routine
• Pain is constant, sharp, spontaneous and may be localized to one or two teeth
• Inability to eat
• Extreme tenderness to palpation or tapping on the infected tooth
Urgent Referral 2 days (2)

Gingiva/ Periodontal:

• Spontaneous and /or prolonged bleeding of gingiva
• Severely altered gingival architecture
• Fever, infection, purulence
Emergency Referral (Same day)

1. Compromised airway, often presenting as difficulty breathing, altered voice, and trismus

2. Rapidly spreading infection

3. Infection/swelling approaching eye

4. Fever, lymphadenopathy, weight loss, extreme fatigue or lethargy, dehydration

5. Spontaneous intraoral hemorrhage
Case 1

• **History:** A 24 year old female presents to the medical office for a routine follow-up evaluation. She has a non-detectable viral load and CD4 count of 550.

• **Chief concern:** “Sore gums for 2 months”
Case 1 (Gingival concerns)

- **Finding:** Gingival inflammation, which started a week after using a new toothpaste.

- **Diagnosis:** Hypersensitivity
  Irritation is due to irritation from abrasive agents in “tartar control” toothpastes, or hypersensitivity to agents.

- **Medical Office Management:** Recommend a fluoride containing toothpaste with no abrasives, whiteners, or “tartar control” agents

- **Referral:** Routine
Case 1 (Tooth-related concerns)

- **Finding:** Asymptomatic, long-standing fractured tooth in mandibular left posterior quadrant

- **Medical Office Management:** No urgent care required for fractured tooth

- **Referral:** Routine
Case 2: “Gums hurt” “Bad breath & a nasty taste”

- **History**: 42 yr. male presents for follow up medical appointment
- **Chief concern**: “Gums hurt” “Bad breath & nasty taste” Pain is diffuse, intermittent, for 3 months
- **Clinical findings**: Plaque and gingivitis
Case 2 – Treatment for gingivitis

Clinical Diagnosis: Chronic plaque-induced gingivitis

Medical Office Management:

- **Rx:** 0.12% chlorhexidine gluconate rinse (Peridex or PerioGard)
  Sig: Rinse with 15 mL and expectorate morning and at bedtime

- **Rx:** Prevident Boost 5000 Toothpaste with Fluoride (1.1% NaF)
  Sig: Use at bedtime every night according to manufacturer's directions

Dental Referral: Routine
Case 3

- **History:** A 22 year-old male complains of “red tender gums.” He has a history of injection drug use, which he discontinued 2 years ago when he was diagnosed with HIV infection. He is somewhat compliant with ART therapy. He brushes once per day.

- **Findings:** Erythematous band-like gingival inflammation, especially prominent in the anterior teeth. If the gingival condition does not improve following a periodontal debridement and improved home care, Linear Gingival Erythema (LGE) may be considered.

- **Photo 2**
Case 4

• **Treatment:** Endodontic procedure “root canal” or extraction. The accumulation of purulence eventually results in creating a tract through the bone and associated expansion of the gingival tissue. The pain often diminishes due to pressure being released when purulence breaks through the bone.

• **Medical Office Management:** Recommend warm salt water rinses. Consider antibiotics for 7 days. Penicillin or Amoxicillin

• **Dental Referral:** Within one week if possible. These may become acutely painful again within 1-2 weeks.
Antibiotics in Dentistry

If no penicillin allergy
- Penicillin VK (500mg)
  Two tablets stat, then one q 6 h for 7 days
  OR
- Amoxicillin 500 mg q 8 h for 7 days

If allergic to penicillin
- Clindamycin 300 mg q 8 h for 7 days
Case 5 – Pericornitis

- **Clinical:** 19 year old male with CD4+ of 310 and Viral Load non-detectable. Compliant with ART.
- **CC:** Moderate pain in lower right for one week
- **Observation:** Inflamed flap of tissue over erupting third molar
Case 5 – Management of pericornitis

Clinical diagnosis: Pericornitis (bacterial infection)

Medical Office Management Considerations:
• Warm salt water rinses bid
• RX: Chlorhexidine 0.12% rinse bid until definitive dental management
• Rx: If swelling and fever, consider po antibiotics i.e., penicillin (PCN) or amoxicillin, if no PCN allergy history
  If PCN allergy, consider po clindamycin
• Analgesics consistent with mild-moderate pain level (NSAIDS or Acetaminophen)

Referral: Appointment within 1 week.
  * Patient should be instructed to call or return to clinic if pain, fever, or swelling increase before dental appointment can be scheduled, or report to ED
Case 6: Floor of mouth

**History:** 31 yr male with rapidly increasing right facial swelling; Poorly controlled diabetic.

**Chief concern:** “Toothache” started in right lower wisdom tooth, five days ago. Dentist provided penicillin, but it is not working.

**Clinical Findings: (as noted in photo)**
- Trismus indicates an infection in the posterior mouth
- Do not “force” the mouth open to evaluate the area
- The trismus will resolve once the infection is resolved
- Temp 101° F

**Diagnosis:** Abscess with multiple space infection

**Management:** Emergency referral to emergency department.
Case 7 – Oral disease secondary to methamphetamine use

• **History:** 23 year male, diagnosed with HIV 1 yr ago. “All my teeth are crumbling, but the top left eye tooth is killing me”. “Also, my gums and the roof of my mouth burn.”

• **Findings:** He has used methamphetamine for 1 year. He is rinsing with OTC peroxide tid, and using OTC topical benzocaine for pain 4-5 times per day.

• **Exam:** Tapping on tooth #11 with a finger elicited sharp pain.
Case 7 – Management of severe dental disease

Clinical diagnoses:

• Acute pain from dental infection due to advanced decay on tooth #11 (Maxillary left cuspid)
• Methamphetamine associated advanced generalized dental decay
• Hyposalivation “dry mouth” from recreational drugs
Case 7 – Management of severe dental disease

Medical Management Considerations:

• Instruct patient to discontinue use of OTC peroxide and excessive benzocaine
• Pain management and nutritional supplementation are very important as a patient in this much discomfort will have trouble eating and taking medications
• OTC Biotene rinse for oral dryness
  Refer for rehabilitation counseling
  Appropriate pain management
  Nutritional counseling/supplementation

Referral:

• Urgent referral oral and maxillofacial surgeon for extraction of tooth #11 and plan for extraction of non-restorable teeth.
OTC agents for xerostomia or ‘dry mouth’

**Mouthrinse**
- Artificial Saliva

**Gum**
- Should be sugar-free, recommend xylitol sweetened
Minor Aphthous Ulcers

• Etiology: An altered local immune response

• Appearance: Round shallow ulcer, < 0.5 cm diameter, with grey/white covering membrane, and red halo

• Usually found on lips, tongue, and soft palate
Treatment of Aphthous Ulcers

Topical Corticosteroids:

• Triamcinolone Acetonide Dental Paste 0.1% (Kenalog and Orabase) Apply small amount with cotton swab to area after meals.

• Dexamethasone elixir 0.5mg/5mL. Disp: 100mL have patient rinse with 5 mL for one minute, then expectorate. Instruct patient not to eat or drink for at least 30 minutes.

• 0.05% fluocinonide ointment (Lidex) with 50:50 orabase. Apply small amount on a cotton swab to area after meals.¹
Case 8

**History:** 23 yr male with extreme oral pain, “Loose teeth and bad breath for at least a month”.

**Findings:** Edematous, erythematous, gingiva that easily bleeds upon palpation. Note the loss of gingival architecture.

**Differential diagnosis:**
- Necrotizing periodontitis
- Uncontrolled insulin dependent diabetes
- Blood dyscrasia such as leukemia
- Drug induced immune suppression

**Dental Referral:** Urgent

**Office Management:**
- Analgesics
- Antibiotics that cover both gram\(^+\) bacteria (Penicillin or Amoxicillin) plus gram\(^-\) bacteria (Metronidazole)
- Chlorhexidine gluconate 0.12% rinse bid
- Nutritional supplementation
Clinical: 28 yr male presents as walk-in emergency to your office “mouth is bleeding”.

Findings: Intraoral spontaneous gingival bleeding and ecchymosis lateral tongue, lips and buccal mucosa. No skin ecchymosis was detected.

Medical Management is key here, there could be an issue with clotting factors or idiopathic thrombocytopenia purpura.

Diagnosis: Spontaneous bleeding due to inadequate clotting factors
Summary

The enhanced ability of the medical team:

1. to screen and triage oral health concerns and
2. to provide education and initial therapy

is a critical step in improving outcomes for patients with HIV infection.
Questions?