Tims Top Tips

1. Pen V 500 mg QDS 5 days (Review after 3) has now replaced Amoxicillin 500 mg TDS 5 days as the first choice of penicillin in both SDCEP and FGDP guidelines. Reasons are that it has been shown to be as effective for dental infections, it is less likely to cause diarrhoea and as it has a narrower spectrum of activity it is more favourable from an AMR consideration. NB if Metronidazole is contraindicated for gram negative anaerobic infections like Pericoronitis, then the alternative is still Amoxicillin because of its broader spectrum of activity. When prophylaxis is indicated the recommendation is still 3g Amoxicillin 1 hour before (SDCEP and FGDP)

2. If Patients are allergic to Penicillin the 2nd line AB is Metronidazole

3. IfT a Macrolide has to be used, then guidelines (SDCEP and FGDP) list Clarithromycin or Azithromycin. These have better gut tolerance, pharmacokinetic properties and there is greater resistance to Erythromycin now due to overuse.

4. The MIC (minimum inhibitory concentration) requires the Metronidazole dose to be 400mg now. Anything less is ineffective and anything more has no increased benefit (SDCEP and FGDP)

5. AB prophylaxis is not indicated for implant placements unless there is an associated bone augmentation.

6. The routine prescribing of clindamycin, cephalosporins and clindamycin is not recommended and should only be at the direction of a specialist in oral/medical microbiology or infectious disease (Quote from FGDP). These 3 drugs have an increased risk of CDiff and are not recommended in primary care dentistry.

7. Only prescribe antibiotics if there is a systemic involvement or if there is a tissue plane involvement with swellings moving towards the eye or neck. All practices should have a Tympanic Membrane Thermometer (£20-£30 at Amazon) and ABs are only indicated if the body temp is 38 Degrees C or above. All patients should be contacted if possible after 3 days and if they are getting better, they should stop taking antibiotics and return the unused ABs to the pharmacy for safe disposal. NB if there has been an interventive procedure this is more likely to be the case.

8. Always gain consent from the patient before prescribing ABs by explaining risks and benefits. If the patient is in pain - painkillers should be prescribed and not ABs. A very high proportion of GDC and NHSE cases include conditions on AB prescribing as a consequence of inadequate records, failure to record a diagnosis and an inappropriate prescription.

9. Patients who present with an acute trismus relating to a wisdom infection should have an immediate referral to A&E or Max Fax as IV ABs are probably indicated as this can develop very quickly into a life-threatening condition.

10. Know all the signs of Sepsis and have them on a Chart in the surgery. If you suspect a patient of presenting with Sepsis then dial 999 for immediate medical attention. These patients can die very quickly.

11. Dentists should not be treating Sinusitis with ABs. 98% of initial presentations are viral (NICE 2017) and sinusitis is a nasal not a dental/oral infection. GDC Standard 7.2.2 states you must only carry out a task or type of treatment if you are confident that you have had the necessary training and are competent to do so. Bacterial sinusitis can lead to very serious medical complications

12. PPIs double the risk of CDiff.

13. make sure you have consent from patients by explaining the risks/benefits of ABs which includes diarrhoea. All Abs can call diarrhoea and be especially careful of those at higher risk of CDiff.

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