THE EDITOR'S CORNER

Drawing the Line on Antibiotics

The editor of any clinical or scientific journal is routinely barraged by news releases that may or may not be relevant to the theme of the publication. I get a substantial number of announcements regarding new dentifrices, for example, that have no specific orthodontic applications. Some of the releases I receive are judged to be of interest to our readers and are included in our monthly Product News section, but most are not. As we assembled this issue of JCO, a news release came across my desk from the ADA—one of many we receive from that organization. At first, I dismissed it as having little relevance to our specialty, but the more I thought about it, the more I came to realize that it is indeed pertinent to those of us in the day-to-day practice of clinical orthodontics.

The statement in question was entitled, "Antibiotics not necessary for most toothaches, according to new ADA guideline":

> *The American Dental Association (ADA) announced today a new guideline indicating that in most cases, antibiotics are not recommended for toothaches. This guidance, published in the November issue of the Journal of the American Dental Association, aligns with the ADA's longstanding antibiotic stewardship efforts and its pledged commitment to the U.S. government's Antimicrobial Resistance Challenge.*
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> *Patients with toothaches are often prescribed antibiotics by physicians and dentists to help relieve signs and symptoms and prevent progression to a more serious condition. However, the new guideline and accompanying systematic review find that healthy adults experiencing a toothache are best served not by antibiotics but by dental treatment and, if needed, over-the-counter pain relievers such as acetaminophen and ibuprofen.*

It's not uncommon for an orthodontic patient to develop a toothache, usually resulting from tooth movement rather than any infectious process. Treatment for this condition is simple: untie the tooth in question; take all orthodontic forces off it for a while (I generally allow a week or so); tell the parents to give the patient whatever over-the-counter medication they would give for a headache, if medication is deemed necessary; then re-engage the tooth with reduced forces when all symptoms have disappeared. Works like a charm. If it is determined that the pain is not associated (or only secondarily so) with tooth movement, then treatment for a genuine toothache is required. For an orthodontist, this would involve referral of the patient back to the primary-care dentist.

Those of us who trained more than a few years ago were taught that when a patient presented with a toothache, it was best to start a course of antibiotics and anti-inflammatories prior to any endodontic or exodontic procedures. The rationale was that it would be difficult to achieve sufficient anesthesia in the presence of active infection with inflammation. There was also the risk of spreading the infection. Recent systematic reviews, however, have indicated that this is not an appropriate course of action, leading to the new guideline from the ADA.

Any health-care professional knows that evidence changes, interpretation of older evidence changes, and opinions vary. Several years ago, I had both of my knees replaced. At that time, antibiotic prophylaxis was deemed absolutely essential before dental treatment of patients with prosthetic joints. Therefore, whenever I went in for a cleaning, my dentist would preload me with clindamycin (since I am allergic to most other antibiotics) and wouldn't touch me until he was certain that I'd had the medication onboard for at least an hour. I had no problem with this regimen; on the other hand, there is no reason to believe that Tootsie Rolls would not have been equally effective. Evidence changed, and a recommendation was made to discontinue antibiotic prophylaxis. That still worked fine for me, until I told my orthopedic surgeon about the revised protocol. He was practically apoplectic. Referring to the authors of the

new guideline, he fumed, "They have never had to deal with an infected prosthetic knee. It's horrible!" That's good enough for me. I continue to take my clindamycin premeds.

The moral of this story is to keep abreast of new developments in the dental and medical fields. Following current institutional recommendations not only provides your patients with up-to-date care, but also ensures that you are following "best practices" from a medicolegal perspective. Still, the doctor's clinical judgement and experience must override any organizational guidelines. If a patient with a toothache shows obvious signs of infection—swelling, fever, pain—then, of course, antibiotics are in order. In such a case, the patient should be seen by the primary-care dentist without delay. If no signs of infection are present, by all means follow the ADA recommendations (and my time-tested protocol): suspend tooth movement and prescribe over-the-counter pain relievers as needed.

RGK