Dental Management in Medically Compromised Patients: An Overview

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Abstract
There is an increasing population of apparently well, but in fact medically compromised people in the community. Most will require dental treatment at some stage and will usually seek it away from a hospital environment. In a recent survey of a general dental practice in Australia it was found that up to 55 per cent of some age groups had concurrent medical problems. Thus there is a real risk that adverse interactions between medical conditions and dental treatment may occur on some occasions, even fatal ones. It is not possible for any individual to know the details of all medical conditions, their treatment and the possible interactions with dental treatment. However, by the application of some sound general principles the risks of any potential interactions can be evaluated. The essential steps for a clinician are: knowledge of the medical history of all patients, potential drug interactions and management of medical emergencies. These principles will be discussed and illustrated by examples of medically compromised patients who may experience common or potentially serious sequela as a result of dental treatment.

Keywords: Dental, Diabetes Mellitus, Management, Treatment

1 | INTRODUCTION

Before initiating treatment, the dental surgeon must know both the physical and emotional status of the patient as this information is important not only for hospitalised and medically compromised patients with complex problems but also for apparently healthy patients undergoing simple exodontia with local anesthesia.¹ For patients with a serious medical illness, who may have a poor understanding of their problems, obtaining a list of medications being taken is often very helpful. Consultation with patient’s physician forms an integral part of the evaluation.² Before initiation of any

Supplementary information The online version of this article (https://doi.org/10.15520/ijcrr.v11i08.832) contains supplementary material, which is available to authorized users.

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ISSN (O) 0976-4852
DOI: https://doi.org/10.15520/ijcrr.v11i08.832
dental treatment most common questions to be asked are:

(1) What is the precise nature of the patient’s disease?

(2) What features of his general condition are likely to influence the course of surgical procedure?

Extensive history and physical examination, laboratory studies and further consultations are required when the answers to these questions are incomplete. Certain protocols must be followed after preoperative evaluation of definite medical conditions that may affect the course of surgery adversely. (3)

2 | DISCUSSION

Proper history, data gathered for evaluation along with laboratory studies and appropriate consultation with the patient’s physician forms a crucial aspect in the dental management of medically compromised patients (1). Present review article highlights the basic guidelines and certain management protocols for patients with medically compromised conditions requiring dental treatment.

1. Bleeding Disorder

It includes any previous unusual bleeding episode after surgery or injury, spontaneous bleeding and easy or frequent bruising. (4) For the purpose of history taking, a clinically significant bleeding episode (5) is one where there is continuous bleeding beyond 12 hours and causes the patient to call or return to dentist or to get hospitalised in emergency care. Also, any history of significant and prolonged bleeding after dental extraction or bleeding from gingiva and nose, a family history of bleeding disorders and complete drug history. (4)

General examination should be done. There may be Multiple purpurae of the skin, bleeding wounds, evident hematomas or swollen joints. Presence of any systemic disease should be confirmed. Liver disease like jaundice, spider nevi, ascites, Cardiac patient show tachycardia or hypertension, which may make hemostasis more difficult to achieve. (4, 6)

Laboratory test of the Hemostatic system : Bleeding time (normal range: 2–7 minutes), Activated partial thromboplastin time (normal range: 25 ± 10 seconds), International normalized ratio (normal range: 1.0), Platelet count (normal range: 150,000-450,000/μL). (5, 6)

Treatment : Tranexamic acid in an oral rinse and Postoperative use of Epsilon-Aminocaproic acid are helpful in prevention of post operative bleeding. (7, 8)

Important Considerations

The minimum blood platelet level before dental surgical procedures should be approximately 50,000/μL, but extensive surgery may require > 100,000/μL. If the count is below this level, replacement therapy may be required. Usually, platelet transfusion is carried out 30 minutes before surgery. (4)

In patients with platelet levels below 100,000/μL, prolonged oozing may occur but local measures are usually sufficient to control the bleeding. In cases of Idiopathic thrombocytopenic purpura, oral systemic steroids may be prescribed 7–10 days before surgery to increase the platelet count to safe levels. (9)

Dental Management

If the procedure has limited invasiveness and the patient has mild bleeding disorder, only slight or no modification will be required but in patients with severe bleeding disorders, the goal is to minimize the challenge to the patient by restoring the hemostatic system to acceptable levels and maintaining hemostasis by local and adjunctive methods. In patients with drug-induced coagulopathies, drugs may be stopped or the doses should be modified. For irreversible coagulopathies, replacement of missing factors may be necessary. (4, 10)

Management in Different Fields

Pain Control

Nerve-block anesthetic injections are contraindicated unless no better alternative and prophylaxis is provided, as the anesthetic solution is deposited in a highly vascularized area, which carries a risk of hematoma formation. (11, 12) The commonly used blocks require minimum clotting factor levels of 20% to 30%. (4) Gross swelling, pain, dysphagia,
respiratory obstruction and risk of death from asphyxia results due to extravasation of blood in the oropharyngeal area by an inferior alveolar block or in the pterygoid plexus. (13, 14) Anesthetic with a vasoconstrictor should be used when possible. Alternative techniques including sedation with diazepam or nitrous oxide-oxygen analgesia, can be employed to reduce or eliminate the need for anesthesia. Patients should be treated under general anesthesia in a hospital operating room when extensive treatment requiring factor replacement is needed. (4)

**Oral Surgery**

Transfusion of appropriate factors to 50% to 100% of normal level is recommended when a single bolus infusion is used in an outpatient setting for coagulopathies. Patient’s hematologist should be consulted before planning and patients with severe disease should be treated in speciality centres. (4)

Local hemostatic agents and techniques such as pressure, surgical packs, sutures and surgical stents may be used individually or in combination and may as-sist in the local delivery of hemostatic agents such as topical thrombin and vasoconstrictors. Caution is needed with the use of vasoconstrictors because of the risk of rebound vasodilatation, which may increase late bleeding risk. The use of absorbable hemostatic materials may favor clot formation and stability (risk of infection and may delay healing; they should therefore be avoided in immunsuppressed patients). (15, 16)

Rapid hemostasis in a wound occur when thrombin is applied, as it converts fibrinogen to fibrin. When used along with antifibrinolytic agents, topical fibrin glue can reduce the amount of factor replacement (17)

It is not so we have to always stop ASA therapy , as local hemostatic measures are sufficient to control bleeding but if it has to be withdrawn , it should be done at least 10 days before surgery. INR(2.0–3.0)is very important to be measured before any surgical procedure specially in patients taking warfarin, if INR is less than 3.0, most oral surgical procedures can be performed without altering the warfarin dose. (18)

Patients on hemodialysis due to end stage renal are taking heparin, which has a short half-life (about 5 hours) and patients can often be treated safely on the days between dialysis. (4) 30 to 40% factor correction is administered within 1 hour before dental treatment for simple extractions of permanent teeth and multirooted primary teeth. Antifibrinolytic therapy should be continued for 5 to 10 days after starting immediately before or after the procedure. Patient should be placed on a clear liquid diet for the first 72 hours followed by a soft, pureed diet for one week and no straws or metal utensils, pacifiers or bottles should be used during this time period. (19)

**Periodontal Procedures**

Common periodontal procedures like periodontal probing, supragingival scaling and polishing can be done normally without the risk of significant bleeding. Factor replacement is seldom needed for subgingival scaling and root planing if these procedures are done carefully. Ultrasonic instrumentation may result in less tissue trauma. For severely inflamed tissues, before deep scaling initial treatment with chlorhexidine mouthwashes and gross debridement is recommended. (20)

Periodontal packing materials and custom vinyl mouthguards (stents) are used to aid in hemostasis and protect the surgical site, (10) and also to enhance effect of periodontal dressing, antifibrinolytic agents may be incorporated into periodontal dressings. To control protracted bleeding post treatment, antifibrinolytic mouthwashes are effective . (4)

**Restorative and Endodontic Procedures**

A rubber dam should be used to prevent laceration of soft tissues by the cutting instruments. Saliva ejectors and high speed suction can injure the mucosa in the floor of the mouth and cause hematoma or ecchymosis; thus, they should be used carefully. Endodontic therapy is preferred over extraction whenever possible in these patients because it does not usually pose any significant risk of bleeding and can be performed routinely. Endodontic surgical procedures may require factor replacement therapy. (1, 4)

**Prosthodontic Procedures**

These procedures do not usually involve a considerable risk of bleeding. Trauma should be minimized by careful post-insertion adjustments. (4)
Orthodontic Procedures

Care must be taken in the adaptation and placement of bands to avoid lacerating the oral mucosa and to avoid leaving protruding sharp edges and wires. Bleeding caused by an accidental scratch or minor laceration of the gingiva usually responds to applied pressure for 5 minutes. The use of preformed orthodontic bands and brackets, which can be bonded directly to the teeth, almost totally eliminates contact of orthodontic appliances with the gingiva during placement. Longer acting wires and springs require less frequent adjustment of orthodontic appliances. (19)

Choice of Medications

ASA and NSAIDS can increase the effect of warfarin. when used for long period. Penicillins, Erythromycin, Metronidazole, Tetracyclines and Micronazole also have potentiating effects on warfarin. (20)

2. Respiratory disorder

(a) Bronchial Asthma

General management includes blood examination for total IgE, skin tests to identify allergens. Measurement of airway obstruction by peak flow meter and avoidance of irritants (21)

Drugs include: Sodium chromoglycate (inhaletal), Bronchodilators and Selective beta 2 agonists e.g. Salbutamol, Terbutaline, Ipratropium Bromide, Theophylline, Corticosteroids (betamethasone). (22)

Dental Aspects

Anxiety may occasionally precipitate asthmatic attacks. So, ask the patient to bring the usual medication during dental treatment. Gentle handling and reassurance is done. (23) Patients may react to sulphites present as preservatives in vasoconstrictor in LA, hence it is better to avoid LA containing adrenaline. If adrenaline is indicated, it is given with an aspirating syringe since adrenaline may enhance risk of dysrhythmias with beta agonists. (24)

Relative analgesia with nitrous oxide is preferable to intravenous sedation and gives more immediate control of patient. Sedatives are better avoided as in an acute asthmatic attack, even benzodiazepines can precipitate respiratory failure. (25) General anaesthesia may be complicated by hypoxia and hypercarbia, which can cause pulmonary edema even if cardiac function is normal and cause cardiac failure if there is cardiac disease. Risk of postoperative collapse of lung is also increased. In case GA is must, ketamine is preferred in children. (26)

Drugs to be avoided are Aspirin, Mefanamic acid, Pentazocine, Morphine, other opioids, Methohexitone, Thiopentone, Suxamethonium, Tubocurarine and Pancuronium, Erythromycin, Clindamycin and Ciprofloxacin. Asthmatic patients are more frequently allergic to penicillin. Acrylic monomer and Cynoacrylates may precipitate an attack. Patients on steroids should be assessed carefully prior to any surgery. (25)

(b) Asthmatic Attacks

It is caused by anxiety, infection and exposure to an allergen. Diagnosis is made by: Breathlessness, Expiratory wheezing and Accessory muscles of respiration are in action and rapid pulse (usually over 110 per min). (1)

Management (27)

- Reassure the patient and terminate dental therapy.
- Position patient comfortably in sitting position
- Administer bronchodilator
- Administer oxygen, continued till hospitalisation.
- Parenteral medication

1. If episode continues , Epinephrine can be repeated in 15 – 20 min. Intravenous medication (optional).

2. If episode continues, Aminophylline very slow IV 5 – 7 mg / kg loading dose

3. Hydrocortisone sodium succinate 25 – 50 mg /kg/dose every 4 -6 hours IV.

- Summon medical assistance.
- Permit patient to recover fully prior to discharge. Treatment may be continued or postponed depending on the patient’s recovery.
3. Cardiac Disorders
General management includes Cardiac surgery and medical treatment for patients with cardiac failures, polycythemias, infections and emotional disturbances. (1)

Dental Aspects
There is risk of infective endocarditis, bleeding tendencies (due to defective platelet function and increased fibrinolytic activity). Cerebral abscess has been reported after dental sepsis following endodontic treatment. Associated disorders-Down’s syndrome, Turner’s syndrome, idiopathic hyperkalemia (William’s syndrome). (1)

Oral Abnormalities
Delayed tooth eruption, positional anomalies, enamel hypoplasia, teeth have bluish white skimmed milk appearance and gross vasodilatation of pulps, increased caries and periodontal diseases due to poor oral hygiene. After cardiotomy, transient small white, non ulcerated mucosal lesions of unknown etiology may be seen. (28)

Rheumatic Fever
General management include use of salicylates for arthritis and penicillin if streptococcal infection is still active. Prompt treatment (24 hours) of a streptococcal sore throat prevents development of rheumatic fever. After an attack, continuous antibiotic prophylaxis to prevent permanent cardiac damage. Oral phenoxymethyl penicillin 500 mg daily until 20 years of age. If allergic, Sulphadimidine 500mg daily are the drug of choice. (29)

Dental Aspects (30)
Emergency dental treatment may be necessary during an attack to relieve toothache but with consultation from physician. LA is preferred but GA is avoided because of possibility of myocarditis. Main risk is of infective endocarditis. Patient should be refer to cardiologist to decide if there has been any valve damage. Antibiotic cover should be given.
Dental disease and treatment as a cause of Infective Endocarditis
5-10% cases occur due to dental treatment but it get reduced after penicillin era
Identification of patient at risk

Thorough medical and dental history
Cardiopulmonary resuscitation equipment should be available.

Planned Preventive Dental Care (30)
Meticulous preventive oral health care should be taken to keep periodontal infection at the lowest level. If extractions are unavoidable, gingiva should be kept healthy to reduce bacteremia. Behavior management is done by conscious sedation and nitrous oxide- oxygen analgesia are beneficial in reducing anxiety. Scaling and antibiotic prophylaxis should be done. Pulp therapy is not recommended for primary teeth with a poor prognosis because of high incidence of associated chronic infection. Extraction of these teeth with appropriate fixed space maintainers is preferred. Endodontic therapy in permanent dentition is usually successful if teeth are carefully selected and the treatment is adequately performed.

Antibiotic prophylaxis requirement for various dental procedures have been mentioned in Table 1 (31)

AAPD Clinical guidelines 2017 (32)
Children not allergic to penicillin
Amox 50 mg/kg (max 2g) orally one hour prior
Children not allergic to penicillin and unable to take oral medication
Ampicillin 50 mg/kg or max 2g IM/IV 30min before Or Cefazolin or Ceftriaxone 50 mg/kg Or 1g IM or IV 30min before
Children allergic to penicillin or ampicillin - oral
Cephalexin 50 mg/kg (2g) orally one hour prior Clindamycin 20mg/kg (max600mg) orally one hour prior Azithromycin or Clarithromycin 15mg/kg (500mg) orally one hour prior
Children allergic to penicillin, unable to take oral medication
Clindamycin 20mg/kg (max 600mg)IV/IM Cefazolin or Ceftriaxone 50mg/kg (max 1g) IV/IM 30 min before

4. Renal Disorders
Bleeding tendencies
Haemostasis is poor due to Impaired platelet adhesiveness and function, defective Von Willebrand’s factor, Lowered platelet factor III (thromboxane),
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### TABLE 1: Treatment requiring Antibiotic Prophylaxis

| Prophylaxis Recommended                                    | Not Recommended                                      |
|------------------------------------------------------------|------------------------------------------------------|
| Dental extraction                                          | Restorations                                         |
| Periodontal procedures including surgery, scaling,         | Non Intraligamentary LA injections                    |
| root planning, probing ,recall.                            | Intracanal endodontic treatment, post placement.     |
| Dental implant,reimplantation of avulsed teeth.            | Suture removal                                       |
| Endodontics or surgery beyond apex.                        | Removable appliances                                  |
| Subgingival antibiotics strip placement.                   | Fluoride treatment                                    |
| Orthodontic band placement.                               | Orthodontic appliance adjustments                     |
| Intraligamentary LA                                        | Shedding of primary teeth                            |
| Prophylaxis of teeth/implants.                             |                                                      |

Raised prostacyclion (PG I)- poor platelet aggregation and vasodilatation. Patients are heparinized during dialysis. Careful haemostasis after oral surgical procedures. Dialysis improves platelet function. Hence, treatment is best carried out on the day after dialysis, when there has been maximum benefit and effect of heparin has worn off. (33)

**Impaired Drug Excretion (34)**

Nephrotoxic drugs - tetracycline, cephaloridine,phenylbutazone, aminoglycosides.

Lignocaine, diazepam and opioids metabolised in liver, hence safer.

Doses of penicillin other than phenoxymethyl penicillin and flucloxacinil, metronidazole and cephaloridine should be reduced since they may be toxic to CNS

Benzyl penicillin has a significant potassium content and is neurotoxic hence avoided

Tetracyclines can cause nitrogen retention, acidosis and worsen renal function.

Doxycycline and minocycline are safe.

Excretion of aspirin and other NSAIDS are delayed. Gastrointestinal bleeding and irritation may be associated with CRF, hence should be avoided.

Codeine and dihydrocodeine can be safely used.

**Anaesthetics**

Local anesthesia is safe unless there is severe bleeding. (1)

Complications with general anaesthesia (35)

Sensitivity to myocardial depressant effect of halothane or cyclopropane and may develop hyperpotension

Enflurane is metabolized to nephrotoxic organic fluoride ions hence used with caution with other nephrotoxic agents. Myocardial depression and cardiac dysarrhythmias likely in poorly controlled metabolic acidosis and hyperkalemia. Isoflurane, Sevoflurane are safer. Induction with methohexitone followed by very light general anaesthesia with nitrous oxide is generally the technique of choice

**Infections (36)**

Poorly controlled since immunosuppressed and may spread locally or result in septicemia. Haemodialysis predisposes to Hepatitis B infection. Tuberculosis is common and Odontogenic infections are treated vigorously.

Dental surgery preferably covered by antibiotic prophylaxis similar to endocarditis prophylaxis. Alternatively, Teicoplanin 400mg IV during dialysis gives cover for at least a day.

Veins of the forearm and saphenous veins are life-lines for the patient on regular haemodialysis, so dentist should use other veins such as those at or above the elbow incase there will be thrombophlebitis. Patients with indwelling peritoneal catheter are not considered to be at risk from infection during dental treatment.

**Post operative complications**

Major surgeries are complicated by hyperkalemia due to tissue damage, acidemia and blood transfusion. It predisposes to dysarrhythmias and cardiac arrest.
Renal Transplantation
These patients are immunosuppressed with corticosteroids that’s why they are liable to infection and carriers of hepatitis virus. In these patients, dental infections may spread with serious complications such as cavernous sinus thrombosis. Oral bacteria are important source of bacteraemias. Oral candidasis may be persistent which is managed with topical Nystatin, Amphotericin or Miconazole. Oral Herpes simplex and zoster can be prevented by low dose acyclovir. Dental pulp narrowing has been noted, apparently due to corticosteroid effect. (1)

Dental aspects of Nephrotic Syndrome
It is similar to chronic renal failure. Long term corticosteroid therapy is the main problem. Infection treatment should be done with corticosteroids and other factors such as electrolyte imbalance, hypoproteinemia and hypopimmunoglobulinemia predispose to infections. (37)

Diabetes Mellitus
Main objective is to maintain the blood glucose at near normal levels and to avoid acute or chronic complications especially hypoglycemic attacks. (1)

Dental Aspects
Drugs like aspirin and steroids should be avoided and Orofacial infections should be vigorously treated. Routine non surgical procedure treatment is best carried out just after breakfast and continuing with the routine antidiabetic medication. Ask the patients to have lunch at the regular time. (1)

Surgical Procedure
The desired blood glucose level is 120 – 180 mg/dl and it should be regularly monitored. Hyperglycemia may be harmful because of delayed wound healing or dysfunction. To avoid Hypoglycemia, IV infusion with glucose which should be measured regularly so that soluble insulin can be added as required. (38)

Management of Diabetes (39)
Diabetics controlled by diet alone
If it is uncontrolled, then blood sugar should be brought to normal level by medication. If blood sugar is well under control, then they can tolerate single extractions under local anesthesia.

Diabetics controlled by diet and oral hypoglycemics
May tolerate minor oral surgeries, provided normal meals are not interrupted. Short procedures under general anesthesia can be carried out without insulin but blood glucose should be monitored 2 hrly.

If it is uncontrolled
Chlorpropamide must be stopped at least 3 days prior because of prolonged action and changed to tolbutamide or glibenclamide or soluble insulin three times daily

1. Admit to hospital 2 days preoperatively for assessment.
2. Morning of operation around 8 am, blood is taken for glucose estimation & IV line is setup.
3. Infusion of 10 percent glucose is started, blood glucose monitored regularly.
   • Oral hypoglycemic should be started after surgery.

Diabetics on insulin
If well controlled, minor surgical procedures can be carried out under local anesthesia. Procedure is carried out within 2 hours of breakfast and morning insulin injection.

Simple treatment under general anesthesia (39)
Admit preoperatively for assessment
Soluble insulin before the anesthesia, confirm by estimation of blood glucose
Operation should be carried out in the morning and booked first in the list.
Glucose 10 g / hour infused till oral feeding can be resumed.
Postoperatively monitored 2- 4 hrly.

Risk of General Anesthesia : Hypoglycemia, Chronic renal failure, Ischemic heart disease and Autonomic neuropathy can lead to postural hypotension.

Management (1, 40)

Hyperglycemia
Though the overall management consists of administration of insulin, dental office management will be supportive.
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If conscious, Terminate dental therapy and immediate Medical consultation is required.
If unconscious, Basic life support, Medical consultation and IV infusion of normal saline.

Hypoglycemia
If conscious, Recognise hypoglycemia and oral carbohydrates sugar dissolved and injected (2 – 4 sugar lumps), or orange juice, cola, candy etc. Observe patient for an hour, if no recovery, then parenteral carbohydrate: 25% and 50% Dextrose. Only used by bolus, or low volume (1-2mls/hour) infusion to correct hypoglycaemia. Before prescribing, consult with physician and also, check blood glucose frequently. Glucagon 1mg IM can be given. Medical assistance, patient should be fully evaluated before leaving dental office.

Unconscious Hypoglycemic Patient (41)
1. Basic Life support and Medical assistance
2. Definitive management
Glucagon 1mg IM restores consciousness in 10 – 15 min
IV 50% dextrose restores consciousness within 5 – 10 min
If both are unavailable, 0.1 mg dose of 1:1000 conc of epinephrine is given SC or IM and repeated every 15 min.
Once consciousness is restored, patients should receive oral carbohydrates.

Convulsive Disorders
Dental environment can provoke seizures even in well-controlled epileptics. Over 90% epileptics have tonic clonic seizures also called grandmal epilepsy. (42)

General Management
Prophylactic anticonvulsants: Carbamazepine, Phenobarbitone, Sodium Valproate, Phenytoin (drugs teratogenic if given during pregnancy), Lamotrigine, Vigabatrin and Gabapentin. (42)

Dental treatment commenced during ‘good phase’ and large dose of lignocaine IV can precipitate attacks. Convulsions and their sequelae Oro – dental complications:

Injuries
Laceration of tongue, Buccal mucosa injury, injuries on face (hematomas, fractures, devitalisation) subluxation and loss of teeth.

Treatment complications
- Phenytoin can cause gingival hyperplasia
- Folate deficieny, Megaloblastic anemia
- Recurrent aphthae
- Dental- Small late erupting teeth.
- Cervical lymphadenopahty
- Phenobarbitone- bullous erythema multiforme
- When carrying out dental treatment, a strong mouth prop should be kept in position and oral cavity kept as free of debris as possible

Drug reactions
Anticonvulsant may increase the risk of hepatotoxicity with paracetamol. Methohexitone, Enflurane and Ketamine, Tricyclic antidepressants, alcohol are epileptogenic. (43)

Management of a Fit in Dental Surgery (43–45)
• Terminate dental care and place patient into a supine position in the dental chair.
• Protect the patient during the clonic phase of the seizure (generalised muscle contractions). Gently hold the patient’s arms and legs. Movement of the limbs should be permitted but within limits so as to prevent injury. Do not totally restrict movement as this may cause injury to the patient. Do not attempt to place any object into the mouth of the convulsing victim as this will usually injure (fracture, avulse) the teeth and injure the soft tissues.
• Call for help.
  (i) Ensure airway patency and administer oxygen to minimise hypoxia and hypercarbia
  (ii) Grandmal epilepsy – cease within 2 -5 min, may continue beyond 5 min or may recur.
(iii) Seizures secondary to LA overdose- until cerebral level of LA falls below seizure threshold, maintain adequate airway and oxygen

(iv) Severe airway obstruction leads to morbidity or death
- If seizure persists, attempt should be made to start an IV infusion.
- IV anticonvulsants
  
  (i) Diazepam 0.2 – 0.5mg / kg per dose IV, repeated at 3 – 5 min.
  (ii) Midazolam 0.2 mg / kg IV bolus followed by 0.1 – 0.2 mg /kg/hr.
  (iii) Barbiturates like thiopental 5-10 mg/kg loading dose IV over 2-5 min followed by 2-10 mg/kg/hr, methohexital, pentobarbital.

- Post seizure management-
  
  (i) Snoring indicates partial airway obstruction in a patient who hasn’t received anticonvulsant. Head tilt / Chin lift, administer oxygen.
  (ii) Mentally disoriented - tell the patient where he is and what has happened and that everything is alright. Complete recovery requires several hours.
  (iii) LA induced seizure secondary to severe anoxia require hospitalization.

3 | CONCLUSION

Dental management in medically compromised patients is very important aspect in daily practice but also it is the most neglected one which results in adverse consequences. Proper emergency kit should be available in every clinic and dentist should have basic knowledge of every medical condition. Also, before commencing any dental procedure or prescribing any medications, prior consultation from the physician should be done.

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How to cite this article: Manihani A.K., Singla K., Vyas D., Sareen K., Parmar E., Arora A. Dental Management in Medically Compromised Patients: An Overview. International Journal of Contemporary Research and Review. 2020;20831–20842. https://doi.org/10.15520/ijcrr.v11i08.832