Dental Emergencies

Workup	• Determine if tooth is primary or permanent • Indication for urgent Dental consult Avulsed permanent tooth (after reimplantation whenever possible) ▪ Extrusion >3 mm or interfering with bite ▪ Laterally luxated (displaced) teeth that interfere with bite (if not interfering with bite, will often spontaneously revert) ▪ Intruded primary teeth ▪ Fractured teeth when dental pulp is exposed (bleeding from central core of tooth) ▪ Suspected dental root or alveolar fracture (e.g. tooth mobility, pain out of proportion when tooth is wiggled) ▪ Suspected jaw fracture (posterior tooth fracture, jaw tenderness, and/or malocclusion) to obtain panoramic radiographs • Imaging: consider XR to search for swallowed or buried (in laceration) tooth
Treatment	• Reimplantation (while awaiting arrival of dental team…) ▪ Avulsed permanent teeth should be reimplanted immediately, ideally within 15 minutes and up to one hour ▪ Store in cold milk or saliva if unable to reimplant ▪ Handle the tooth carefully by the crown to prevent damage to the periodontal ligament ▪ Remove debris by gentle rinsing with saline or tap water; do not attempt to sterilize or scrub the tooth ▪ Reimplant manually ▪ Keep the tooth in place by having the child hold it or bite on a gauze pad or clean towel. • Uncomplicated fracture of permanent tooth: ▪ Store tooth fragments in tap water to prevent discoloration ▪ Dental follow-up within a few days to bond fracture piece or smooth a fracture • Other injuries (infraction, concussion, subluxation) warrant outpatient dental referral • General aftercare ▪ Soft diet for up to 10 days and limit sucking (pacifier or digit) ▪ Continue brushing with a soft-bristled toothbrush ▪ Avoid flossing until healing has occurred ▪ Chlorhexidine mouthrinse for luxation of permanent teeth ▪ Tetanus prophylaxis, for dirty wounds, avulsed teeth, deep lacerations, or marked luxation injuries

Epistaxis

Sources	Messner AH. Management of epistaxis in children. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Accessed on January 25, 2016.) Acknowledgements: Ali Baker
Pathogenesis	The anterior nasal septum is highly vascularized (Kiesselbach's plexus) and is subject to exposure due to location.
Etiology	• Trauma (including nose-picking) • Mucosal irritation: allergic rhinitis, viral URI, dry environment • Tumor: nasopharyngeal angiofibroma, pyogenic granuloma, papilloma • Vascular abnormality • Coagulopathy • Inflammatory: Granulomatosis with polyangiitis (GPA), formerly called Wegener's
Clinical Presentation	• Active bleeding or dried blood • Nasal mucosa: may be dry, cracked, pale, boggy, or have prominent vessels • If there is active bleeding, look for vessels involved • Exclude masses, polyps, foreign bodies • Exclude underlying bleeding disorder: ecchymosis, petechiae
Workup	No studies are routinely required • Hematologic and coagulation studies if history suggests personal or family history of bleeding disorder • CT or MRI if malignancy is suspected

Epitaxis continued on next page →