


I'm not robot  reCAPTCHA

**Continue**

## Android textview set default color

Complications in the third molar exodontics occur when we undergo such frequent surgery may experience some intraoperative or postoperative complications. In any case the dentist at the dental clinic in Barcelona Propdental is responsible for this operation prepared and very well qualified to solve any problem, reaction or adverse effect that may arise for you. We would define complication as an unpleasant event that occurs during or after an intervention. If this event is not addressed, it could have serious and more serious consequences. Complications that can occur when removing the third molar are the same as when removing any other tooth. This may be due to the complexity of the included tooth extraction technique. We can separate complications between intraoperative complications that occur during surgery occurs. Immediate postoperative ones that occur within 24 hours of surgery and are late, which can occur after 24 hours, and which may even leave sequelae. Intraoperative complicationsGemorrhah: Hemorrhage can be caused by damage to a vessel of a certain caliber that the injury can bleed and prevent the dentist to see the field of surgery. Treatment of these cases would be to clamp the bleeding vessel with mosquitoes like a hemomic clamp and then do ligation or electrocoagulation of the vessel. Fractures: During the extraction of the third molar, one of the molar roots may break any of its parts or damage to a nearby tooth. Fractures usually occur by applying excessive force to the bot during dislocation. Moves: Movements that may occur in a fragment or throughout the third molar can occur very often when trying to extract them with elevators. The most common jaw shifts are the lower dental duct, the floor of the mouth and the swing space. Soft tissue dlocation: Tears caused by the mucous membrane are usually caused by inadequate flap design when the flap is insufficient and the separator applies excessive stress at the ends of the incision. Burns and abrasions can also be caused on an anesthetic lip by applying a heated arm clip during an osteotomy or dentistry. Subcutaneous emphysema: subcutaneous emphysema usually occurs when using a turbine in surgical exodontics. It's a foray. deep tissue of the face. If this complication occurs, hospitalization of the patient will urgently need to check and control the infection. Nerve lesions: During the removal of molars can be damaged to varying degrees, the lingune nerve is like the lower dental nerve. These lesions can cause transient or permanent changes to the affected nerve. Postoperative complicationsOf postoperative complications we can find two types, immediate complications that are observed shortly after the end of surgery and late complications that we can observe them a few days after operation. Immediate postoperative complications: Between the first 12 and 24 hours after surgery, it is normal small bleeding that may appear, it is controlled by putting some pressure on the gauze. But in case of enough blood, you will have to be much more attentive to the patient and carry out checks of vital signs: control of breathing, pulse and blood pressure. It is necessary to work out the surgical examination of the operating area in place and to solve the problem of the origin of bleeding. The bruises on the patient's skin can be caused, due to the collection of blood that comes to dissociate the facial planes or periosteum, and all clinically translated by the appearance of tumefaction, echinamosis and palpation mass stiff consistency. Another of the most common complications is Trismo, after surgery many patients have an inability or restriction to open their mouth to normal limits. This may be due to several causes, such as: Protective muscle contraction due to inflammation, postoperative pain, the presence of infection in adjacent spaces or may also be due to injury to the visomandibular joint during surgery. There may also be cases where the patient has the appearance of herptic bubbles or other unpleasant performances that are most caused by psychological stress. And finally, there are several patients who demonstrate rejections and reactions to the medications they are sent because they may have some kind of digestive intolerance, stomach or abdominal pain, vomiting... Or also allergic manifestations.Late postoperative complications: After the surgery is completed, the patient notices very severe pain in the area operated on 3 or 4 days after it is performed, it can be several problems that need to be monitored and treated to prevent him from achieving any serious problems. One of the most common and common problems is that the wound, despite being cleared and Get. The infection may have appeared for a variety of reasons, such as pericoronitis or dental absceso. With the right antibiotic, it is usually enough to control this complication. We can also find the patient's abductions, which usually occur when the surgical wound does not open properly, creating an infection that can become infected and cause supulation or granular tissue formation. In order to avoid the vast majority of complications after surgery it is very important to follow all the advice that the dentist should give the patient, so that the wound can heal well and properly without suffering any problems and that it may end up recovering as soon as possible. In case you have any problems, you should go to the dentist at the dental clinic in Barcelona or Madrid de Propdental so that it can help you immediately. About the author: Third molar surgery is the most common procedure performed by oral and maxillofacial surgeons. A deep understanding of the complications associated with this procedure will allow the practitioner to identify and advise high-risk patients, properly manage the most common complications, and be aware of less common sequels and the most effective management methods. Surgical removal of third molars is often accompanied by pain, swelling, trism and general oral dysfunction during the healing phase. Surgical treatment and scrupulous perioperative care can minimize the incidence of complications and limit their severity. While this article describes complications and handling, it is in no way a comprehensive assessment of current publications. Light bleeding, surgical swelling, three, and postoperative pain complications such as pain, swelling, and trism are glutonies expected after the removal of third molars. Although transient, these conditions can be a source of anxiety for the patient. Much of this anxiety can be mitigated if there is a preoperative discussion than expected in the perioperative course. Light bleeding can be effectively controlled by local measures. Most bleeding can be administered by applying a gauze cork over the extraction site with direct focused pressure. Permanent intraoperative bleeding can usually be controlled with additional stitches to the wound. Other surgical acillaries include the use of topical thrombin to the wound or through coatings such as gelfous or surgical. Arterial bleeding, if detected, is best treated with vascular identification and subsequent ligation Couteri. Surgical swelling is an expected continuation of the removal of affected teeth. Inflammation usually reaches a maximum level of 2 to 3 days after surgery and should disappear within 4 days and be completely resolved within 7 days. The use of ice and head lifting in the perioperative period can limit postoperative inflammation and improve patient comfort. Preoperative use of systemic corticosteroids has been recommended to reduce immediate swelling, but disputes about its effectiveness still exist. Trism is often the result of a surgical injury and is secondary to chewing muscle and facial inflammation. As with surgical swelling, there is evidence to support preoperative steroid use in reducing postoperative trism. However, there is currently no agreement on the most useful dose, type or time of administration. Preoperative inter-consciousness measurement of discovery and subsequent measures ensure that the patient returns to the preoperative level of function. Pain caused by third moly surgery usually begins after anesthesia from a reduced procedure and reaches a maximum level of 6 to 12 hours of postoperative. Pain is expected, and the use of numerous painkillers, including non-steroidal and narcotic anti-inflammatory drugs, have been recommended for management. Selected studies have suggested a role for preoperative use of non-steroidal anti-inflammatory drugs to reduce postoperative pain. The most common complication and their management of Osteitis alveolar alveolar osteoith is one of the most common complications associated with third molar surgery. It is characterized by severe throbbing pain, which usually begins 3-5 days after surgery. This time, most of the pain and inflammation associated with surgical trauma should go away, and irradiated residual pain in the ear is a common complaint in patients with alveolar osteoarthritis. The causes of this painful condition, commonly known as dry alveolite, are not fully known, but are considered to be associated with malformations or blood clots in the newly extracted third molar cavity. While the evidence supports the argument that alveolar osteoarthritis can be caused independently of philolithis, the destruction of a blood clot formed by invading oral bacteria is generally regarded as the most important etiological factor. This finding is based on evidence indicating that the use of antifibrinolytic agents reduces the incidence of alveolar osteophyloma and that saliva with a high bacterial number incidence. Overall rates of alveolar osteoith range from 1% to 30% in publications. The variability of the interest presented is largely due to ambiguous diagnostic criteria. Numerous authors have shown that factors such as age, gender, surgical experience, tobacco use, and the use of intraoperative irrigation affect the incidence of alveolar osteoith, but the mechanism of its effects is unclear. Surgery of the third jaw molar is more commonly associated with alveolar osteositis than the operation of the third jaw molar. The incidence also increases with the patient's age. Patients under the age of 20 are considered a low-risk group for this problem, which may be because the bone in these patients has more elasticity, circulation and greater healing capacity (6,13,14). Patients taking oral contraceptives, and patients who are regular smokers, appear to be at increased risk of developing alveolar osteoarthritis. The onset of alveolith, which is higher in women than in men, possibly using oral contraceptives (5,6), has been found to be higher. Surgical experience appears to be back linked to the incidence of alveolar osteoarthritis (5.15). Patients with pre-existing perionitis and patients with poor oral hygiene have an increased risk of developing osteoarthritis, indicating the role of bacteria in fibrillation. Methods to reduce the incidence of alveolar osteositis are recommended. Depending on the patient's level of risk, different ways of doing things may be outlined. Some researchers advocated the regular use of preventive agents for inexperienced surgeons. Several steps can be taken to reduce the incidence of alveolar osteoith, including the evacuation of the cavity by salt irrigation, the use of topical antibiotics such as tetracycline powder, inside the cavity, the placement of antibiotic-soaked helmwape, and perioperative use of chlorhexidine. Early postoperative infections Due to the wide range of native oral flora, postoperative infection is a concern. While the use of aseptic techniques, hemostasis, careful tissue management, and careful and thorough site removal washing can reduce the likelihood of postoperative infection, the regular use of antibiotic therapy to prevent infection is still being discussed. Total infection as a result of the extraction of the third molar range from 3% to 5% (14.21). It has been suggested that postoperative infection rates are higher for bone jaw exposure than for any other type of extraction, reflecting an increase in surgical trauma (13-15). Surgical experience can also affect the rate of secondary infection (14.15). Systemic antibiotics are recommended for infection prevention in patients with gingivitis, pericoronitis or common debilitating diseases, but their effectiveness in reducing postoperative infections is controversial (19,20,22). Incidence of deep infection in the facial space is low (6,23,24). Treatment of the most serious infections depends on the severity. Treatment should include proper assessment and treatment of the airways, proper imaging, dependent drainage with a culture and sensitivity test, and proper use of antibiotics. Excessive postoperative bleeding Excessive bleeding is defined as bleeding outside of what is expected from continuous removal or bleeding outside the postoperative window to form a blood clot (6-12 hours). Several risk factors for postoperative excessive bleeding associated with the third molar surgery have been identified and treatments (6,15,25-28) have been studied. Excessive bleeding and bleeding are reported to occur between 1% and 6% in the third molar surgery (25.26). Preoperative assessment of internal bleeding and use of anticoagulant and antithrombocyte drugs (ASA, Coumadin, Plavix) are necessary. Because of the risk of reported factors, the most important is the level of exposure and its proximity to the neuro-vascular package (15,27,28). The occurrence of excessive bleeding was reported more often with the extraction of the third jaw of molars against their jaws by colleagues. Excessive bleeding is the most common, regardless of the type of exposure, of inexperienced surgeons (15.27). It is also most commonly reported in older patients, probably due to vascular fragility and less effective clotting mechanisms (26.27). It has been reported that men are 60% more likely to suffer from excessive bleeding than women, possibly due to the higher frequency of contraceptive use in women and the positive effects of oral contraceptives on blood clotting. Identifying patients at risk is an important first step in assessing the likelihood of bleeding complications after the third moly surgery. During pre-operative consultation, it is essential that the surgeon past and the onset of related hemorrhagic complications. Any family history of blood diseases must be obtained. Excessive bleeding with temporary loss of teeth and, in women, a history of menorrhagia, can be suggestive based on coagulopathy. During surgery, careful management of soft tissues and local measures can control and prevent most bleeding problems. Bleeding, which cannot be controlled by local measures, is rare. In these isolated cases, interventional radiology may be required with selective embolization or identification of the proximal vessel and ligation. Wound healing problems Risk factors for poor wound healing have been identified. In 1993, a seminar of the American Association of Oral and Maxillofacial Surgery (AAOMS) identified the following patient risk factors: pathogenic accumulation and periodontal adherence, wound-related, tobacco use and an increase in age by more than 25 years. The report also states that wound healing occurs faster and complications are less common when third molars are removed before the roots develop fully and that various factors affect age-independent wound healing. Patients who exhibited at least three of the following factors were identified to have an increased risk of wound interaction: the dystal defects of the second molar skin, the increase in the mesoangular positioning of the third molar, the proximity and contact of the roots of the second and third molars, and the reabsorption of the second molar root. Identifying high-risk patients prior to intervention and intervention of specific cases are the best ways to minimize the problem. Less common complications and treatment fractures, even if they occur infrequently (0.00049 %) During the removal of third molars, jaw fractures (Figure 1) have serious consequences, especially if they are associated with nerve damage. Fractures usually occur when excessive force is used to remove a tooth, although even small forces can cause deep exposure to tooth fractures. Because of very few cases, it is difficult to identify specific risk factors. Some studies have shown that age is an increased risk factor. A fracture

can also occur late, sometimes a few weeks after tooth extraction. Treatment should include a standard approach to reduction and stabilization using intermaxillation or rigid internal fixation (Figure 2). Damage to neighboring teeth, thanks to the force needed to remove third molars, can damage adjacent teeth during the procedure. Accidental fracture of adjacent teeth can be minimized if measures are taken to visualize the entire operating field instead of the tooth or teeth that will be removed. A surgeon who works about the periphery of the operating field is often able to anticipate possible damage and take steps to prevent it from occurring. Even with proper awareness and careful surgical technique, seriously restored tooth or cavity fractures are sometimes inevitable. Pre-operative discussion of fractures is the best measure. When there is teeth or cavity recovery, the doctor should inform the patient of the possibility that these structures may be damaged and explain what will be done in case this happens. If the adjacent tooth is inadvertently dislocated or shrouded, the most common course of action is to reposition the tooth and then fixation, if necessary. Fixing can often be obtained by using additional stitches placed lateral across the occlusion surface as the tooth is in place. The use of other fasteners, including dental wires, nasal grate and composite tyres, was also effective. Periodontal defects of periodontal defects after the third molar surgery can often be expected before surgery depending on the age of the patient and preoperative periodontal health. Although there is debate over the elimination of third asymptomatic molars, it is generally accepted that preventive extraction is deeply affected by third molars is not suitable for elderly patients with good periodontal health. A common problem is the effect of removing third molars on healthy periodontal of second molars, in particular, bone height and bag depth. In most cases, there is a slight difference between preoperative and postoperative bone height on the distal side of the second molar (41.42). With this in mind, it is generally accepted that bone healing is more predictable if the third molar is eliminated prior to the presence of bone loss along the distal face of the second molar (42-44). In general, common periodontal defects after the third molar surgery are most likely to occur in elderly patients (35 years), especially if there is bone loss along the distal face of the second molar and if there are periodontal lesions that are usually associated with the existence of a third erupting molars For these patients, it is not recommended to perform extractions if pathological signs have made surgery necessary. Oroantral communication and the formation of fistulas Sometimes the extraction of third maxillary molars results in communication between the oral cavity and the maxillary sinus. For deeply affected jaw molars and teeth, which have roots with a large area of surface, the antral soil can disturb during tooth extraction. The two common sequelae associated with this complication are maxhas-sinus sinusitis and chronic formation of anoantral fistula. The severity of these conditions is largely dictated by the size of the connection and the preoperative state of the paranasal breast. Preoperative images are useful, but do not fully anticipate the complication of the breast. Treatment of oral fistulas depends on the size of the hole between the jaw-synus and the oral cavity. If the hole is small (2 mm in diameter), surgery is rarely necessary and closure usually follows effective treatment. Patients should be instructed not to engage in activities that quickly change the balance of paranoid breast pressure, including blowing the nose, smoking and blunt taunt. Large holes (diameter 2-6 mm) may require additional seam to contain the blood clot and facilitate healing, as well as a course of antibiotics and further use of commercial oral or nasal decongestants. For large fistulas (≥ 7 mm in diameter) and for patients with a history of secondary chronic sinusitis, surgery is recommended, including sinus debrication and drainage, polypeectomy and closure by developing a flap. Antibiotics and decongestant therapy should also be prescribed. Moving teeth moving teeth or fragments of teeth in facial spaces or maxillofacial sinuses, although they do not occur normally, is something that requires attention. Anecdotal descriptions of these facts are common. The decision to remove teeth after displacement should be planned using 3D analysis of X-rays or tomographic cuts. Nervous lesions after the removal of the third molar Among the most serious and widely discussed postoperative complications arising from the third molar surgery is a trigeminal nerve injury, in particular, the involvement of any of the nerves in the lower alveolar or linchral. These nerves can be damaged by direct or indirect forces. Direct injuries include those resulting from injections crush injuries, injuries sustained during tissue removal or soft treatment, and damage caused by the use of tools. Indirect nerve damage can be the result of physiological phenomena, including root infections, blood pressure and postoperative swelling. The overall risk of lower nerve damage associated with the third molars removal scale ranges from 0.5% to 5% (47.48). In most cases, the injured nerve recovers spontaneously. The reported rate of permanent injury to the lower lower lower nerve is significantly less than 1% (49-55). The proximity of the root of the third jaw molar and the lower alveolar nerve can be assumed from panoramic or periapical X-rays. Statistically, the most risky radiological signs include narrowing or deviation of the channel, loss of the contour of the cortical channel and an increase in radio prodrance over the root. Although these characteristics provide preliminary evidence that a nerve can be found during extraction, lesions may occur regardless of the presence of any of these factors. The incidence of lingual nerve injury is much lower than in the lower alveolar nerve injury and ranges from 0.02% to 0.06%. In the presence of injury, however, spontaneous recovery is less common (56-60). The anatomical position of the lingual nerve varies considerably. Although the nerve itself is usually located next to the lingune bark of the third midpar molar, it can be located anywhere in the space between the cte muscle and the gingivalic groove. The soft tissue manipulation involving the height and protection of the lingola periosteus (performed as a routine during the linguistic divisive method) has been discussed as an etiological factor for the transient injury of the lingual nerve. There is a descriptive nomenclature for classifying a nerve injury. The generally accepted classification divides neural trauma into three categories: neuropraxia, axonothymosis and neurotmesis. Inhibition of conductivity signals caused by damage to the myelin shell is known as neuropraxia. Disruption of the axonal system unaccompanied by nerve damage is known as axonothymosis. Neurotmesis involves damage to nerve fibers, usually resulting from nerve rupture and destruction of adjacent connective tissue. In addition to direct recognition of intraoperative nerve lesions, subjective neural postoperative dysfunction (dysesthesia, paresthesia, anesthesia) provides a thorough study of the possibility of injury Nerve. Complete and thorough sensory testing and documentation are essential. Accepted techniques include subtle touch and direction of proprioception examination, consistent use of von Frey's hair, temperature feelings, and detection of sharp, insensitive objects. A subjective taste assessment should also be documented. It's a good idea to use the chart and its chart. Although the frequency of permanent nerve dysfunction is rare, early consultation with a microsurgical specialist is correct, as early surgical repair has been shown to be associated with more favorable results. Factors that predispose patients to specific nerve lesions have been thoroughly investigated and identified. Dental, radiological and patient variables can affect the frequency of nerve damage. It has been shown that the proximity of the root to the lower lower lower lower part of the canal, determined by X-rays, predicts trauma. Surgical removal of horizontally and mesoangularly affected teeth is also more likely to cause nerve damage, probably due to increased surgical manipulation and the impact required to remove these teeth. Postoperative bleeding from the recovery site was also involved in the onset of dissesis. There is no conclusive evidence regarding attitudes to age, gender and race and the frequency of nerve injuries. Several researchers have tried to study the effect of modified surgical techniques on the frequency of nerve injuries, without definitive results. The most effective treatment for nerve lesions remains a combination of preoperative X-ray assessment, patients' analysis of the possibility of injury and a cautious approach to high-risk patients (or patients whose radiographic traits indicate a close anatomical link between the tooth root and the lower alveolar nerve (IAN) , changes in surgical approaches may be attempted to minimize the potential for nerve damage (Figure 3-5). Despite technological advances, informed consent to the frequency of nerve injuries is important. A full explanation of the possibility of nerve damage, associated symptoms and treatments for such injuries can help prevent significant difficulties patient and practitioner. An open dialogue between the patient and the doctor before surgery, explaining possible complications and treatment options, can help prevent further lawsuits. COMPLICATIONS RELATED TO THE EXTRACTION OF RETAINED TEETH Each surgical procedure results in a certain degree of postoperative bleeding and inflammation, which usually manifest as pain and swelling. Thanks to the body's inflammatory response and natural progression for treatment, wound repair and tissue regeneration are activated, and physiological mediators concentrate in the area of the wound, which leads to induction of the nociceptive pathway and changes in vascular permeability. Although the complex physiology of the human body goes beyond this article, the doctor must understand the timing of these processes to determine whether a patient's complaint is postoperative bleeding, pain or swelling a normal response in response to a surgical injury or an abnormal response.27 Preoperative evaluation of the third molar, both clinically and radiographically, is important during the surgical procedure to remove as a result of exposure to the teeth. The classification is based on the angulation of the affected tooth, the ratio of the affected tooth to the front edge of the branch and the second molar, the depth of impact and the type of tissue that covers the tooth affected. According to the literature, the mesoangular effect, which accounts for 45% of all shock molars of the third jaw, is the least difficult to eliminate. Vertical impact (40% of all strokes) and horizontal impact (10%) have intermediate complexity, while the softened impact (5%) This is the most difficult.27 The depth of exposure under solid and soft tissue is also an important factor for determining the degree of difficulty. Root morphology also plays an important role. Root anatomy can be conical and fused, or separate and divergent, the latter harder to manage.27 Another important determinant of the complexity of extraction is the age of the patient. When exposed to teeth removed before the age of 20, there are fewer complications. The roots are usually formed in two-thirds, and are often separated from the lower alveolar nerve, allowing minimal bone extraction and fewer complications during tooth extraction. There is usually a wider pericoroon space formed by the dental follicle, which provides additional access to remove the tooth without a lot of bone extraction. However teeth in patients of older groups (aged 40 years) are more complex, with an increased risk of complications. Longer roots are often fully formed, requiring greater bone extraction, and their apical location is closer to the lower alveolar, increasing the risk of postoperative anesthesia or paresthesia. In addition, there is a higher density and lower elasticity in the bone with age.27 Surgical damage to adjacent structures27 Sometimes, the percussion tooth is located in such a way that its extraction can seriously compromise the adjacent vital structures, so it is reasonable to leave the tooth exposed in place. Possible risks, benefits and alternatives should be carefully discussed with the patient prior to consent. At the end of development, third molars with full bone exposure can be placed in close proximity or through the lower alveolar nerve channel. It may be wise to leave the tooth effect (if asymptomatic) in place rather than the risk of paresthesia or anesthesia of the lower alveolar nerve. Surgical removal of exposure to third molars can lead to significant bone defects that cannot heal properly in elderly or medically compromised patients and can lead to loss of adjacent teeth rather than improving or maintaining periodontal health. Hemorrhage27 Bleeding can be minimized with the help of perfect surgical technique and avoid external force, flap rupture, or excessive soft tissue injury lining it. When the vessel is cut or cut, the bleeding should be stopped for some measure to prevent secondary bleeding after surgery. The most effective method of obtaining hemostasis after surgery is the use of wet gauze packaging and the bite of the patient directly over the site with the correct application of pressure. Your doctor may prevent excessive postoperative bleeding by carefully managing the intraoperative tissue. However, in some patients immediate postoperative hemostasis is difficult. In such situations, various measures can be used to promote local hemostasis, including additional stitches, the use of topical thrombin, oxidized cellulose, kitozin bandage, reabsorbed gelatin sponge and the use of local anesthesia with epinephrine. Patients who have known acquired or congenital coagulopathy require extensive preoperative training and planning. Postoperative bleeding is a common continuation of any dentoalveolar procedure. In healthy patients, postoperative bleeding is usually minimal and self-limiting by the cascade of body clotting. Line the time of blood clots usually is 6 to 12 hours after surgery. Continuous active bleeding after the twelfth hour is considered excessive and should be of concern. The patient must be taken to the emergency room for immediate care. Patients with warfarin, for example, are a common problem for surgical procedures performed by doctors. Major medical problems, such as prolonged atrial fibrillation, deep vein thrombosis, prosthetic heart valve or myocardial infarction, often prohibit stopping the anticoagulant. An acceptable treatment strategy is to hospitalize the patient, discontinue treatment and keep the patient on reducing the heparin regimen until the prothrombin time index (TP) - The International Standardized Report (INR) is at a therapeutic level. The warning should be performed while planning treatment when considering the type of dental surgery performed. Many minor oral surgical procedures can be performed while the patient is anticoagulated. In general, for patients with warfarin, PT-INR less than 2.5 is acceptable if multiple extractions are required. To extract 1 to 3 teeth, without back teeth or surgical extractions, INR less than 3.0 is acceptable. Thus, for patients in need of multiple extractions, staged visits are appropriate to prevent disruption of anticoagulants. Edema27 Postgurgic swelling or swelling is an expected side effect of the third molar surgery. The onset of inflammation is usually between 12 and 24 hours, with a maximum observed frequency of 48 to 72 hours after surgery. Eden usually begins to subside within 4 days of surgery, and most patients experience full resolution in 5 to 7 days. A cold compress can be used to minimize the onset of swelling and help reduce chronic stabbing pain. It is important to educate patients about this time and that swelling is often expected. In addition, patients sleep with their heads raised and do not sleep on their sides to avoid any dependent swelling. In addition, perioperative steroids can be used to prevent blotting in patients undergoing invasive procedures (i.e. extraction of third molars with full bone exposure). Perioperative steroids produce a moderate to noticeable reduction in swelling, but a brief effect in their effects. Infection27 Another postoperative complication associated with the removal of the shock of third molars is an infection. Incidence of infection after removal by third parties is low, from just 1.7% to 2.7%. About 50% of localized subperiottic abscess infections occur 2-4 weeks after the postoperative course without problems. These infections are often attributed to remains that remain under the mucous flap. Treatment is simply surgical debritation and drainage. Of the remaining 50%, several postoperative infections are important enough to justify surgery, antibiotics or hospitalization. Infections occur only within the first 7 days from 0.5% to 1% of the time. According to the literature, this situation is considered an acceptable infection, which does not justify the introduction of prophylactic antibiotics. There is a wide range of bacterial flora in the mouth. Thus, any intraoral area is exposed to certain aerobic, anaerobic and optional organisms with pathogenic potential. Prevention of postoperative infection begins with the identification of a patient with a medical risk. In addition, the incidence of postoperative inflammatory complications increases with age, smoking, pre-existing infection/disease in the surgical field, oral contraceptive pharmacotherapy in women and, ultimately, lack of surgical experience of the doctor. When it comes to affected teeth, the third jaw of molars has been shown to have a higher rate of postoperative infections than jaw teeth. As with other common complications, careful tissue management, debritation/treatment of necrotic/infected tissues and complete wound irrigation with normal saline solution or chlrohexitidine reduces the amount of harmful bacteria in the wound site, reducing the likelihood of infection. Alveolar fracture27 of Alveola fractures should be taken into account in differential diagnosis of persistent pain or swelling after dentoalveolar procedures. Fractures are the result of the use of excessive force in tooth extraction. If not recognized and untreated, such fractures can progress to malocclusion, defective binding, infection and parties. During the initial assessment, the main risk factor should include the patient's age, because loss of bone density, elasticity and strength are often correlated with older patients. In addition, atrophic jaws or jaws with large intra-canal defects are also at increased risk of fracture. Fracture recognition is the most important management. It can manifest itself as a moving alveolar segment or malocclusion. In the postoperative period, any patient who is queried with malocclusion, pain and swelling to the procedure, displacement or mobility of the tooth or persistent parties should be evaluated for a possible fracture of the alveolar. Once the fracture is identified by panoramic X-rays or COMputed tomography (CT), treatment is guided by fracture nature and functional limitation. Treatment ranges from changes in the patient's diet and early immobilization to internal contraction and fixation of fractures. Root fracture27 One of the most common problems when removing third molars is a fracture of the root, which can be difficult to recover. In such situations, the root fragment can move into the submandibular space, the lower alveolar canal or the sinus of the jaw. Un-infected roots inside the alveolar bone have been shown to remain in place without postoperative complications. The tissue of the pulp is exposed to fibrosis, and the root is fully incorporated into the alveolar bone. Aggressive attempts to remove parts of the roots that are in an unstable position cause more harm than profit when X-ray tracking may be all that is required. When such excessive force is applied to the tooth, the vapor generated generates a fracture at the junction between the part of the root still attached to the alveolar bone and the part already released from the alveoli wall. If there is a fracture of the root, the nest should be abundantly irrigated with normal saline solution, and should try to directly visualize the root or tip of the preserved root. For teeth with no preoperative signs of disease or periaictic infection, small root tips less than 3 mm can be stored without side effects. For the back teeth, the risk of damage to the maxi groove or lower alveolar nerve often outweighs the risk of leaving the fragment in place. However, if there is a tooth-related disease prior to surgery, it is imperative that the root fragment be removed. Alveolar osteoi27 Incidence of alveolar osteoarthritis or dried alveolith after extraction of shock molars of the third jaw is between 3% and 30%. When a dry socket is determined in terms of pain, which requires the patient to look for follow-up, the incidence is between 20% and 25%. The pathogenesis of alveolar osteoith has not been clearly defined, but the condition is most likely the result of whether a blood clot is formed before the clot is replaced by the granulation of the tissue, causing the alveolar bone to be exposed. The fibrillation process takes place 3-4 days after extraction. Patients are present with severe stabbing and radiating pain, often associated with the foul smell of the surgical site, and trism. Teh Fibrinolytic agents can come from tissues, saliva or bacteria. The incidence of dry alveolith is higher in patients with a social history of smoking. Women who take oral contraceptives also have a risk of alveolar osteoarthritis. Its appearance can be reduced by reducing bacterial contamination of the surgical area. This goal can initially be achieved by pre-surgical rinsing of chlrogexydine, which reduces the incidence of alveolith by up to 50%. The abundant irrigation of the surgical area with normal saline throughout the procedure is also effective. The solution to the pollution problem is dilution. Use topical drugs, antibiotics such as tetracycline, clot stabilizers (Pfizer, Distributed Pharmacia and UpJohn Company, Pfizer INC. Division, New York, NY, U.S.), platelet-rich plasma and medicinal mouthwash has also been proposed to prevent alveolar osteoarthritis. The number changed daily for approximately 7 days. Pain is usually allowed in 3 to 5 days, although in some patients it can take 10 to 14 days. , while the lower alveolar nerve is damaged during the extraction process itself. According to the literature, the accepted incidence of alveolar and lower lingual nerve injuries after the third molar surgery is about 3%. Episodes of the party should be transient only after routine surgical extractions. However, up to 45% of nerve compression lesions, which are characteristic in the third molar surgery, lead to permanent sensory abnormalities. The most common predisposing factor is the complete bone exposure of the third midibar molar, which mainly affects the mesoangular and vertical effects. In some cases, the proximity of nerves to the root indicates a clear narrowing of the lower alveolar canal when it crosses the division of the root or root adjacent to the canal. Other radiographic finds include diverting the channel path through the tooth, darkening the apical end of the root (indicating that it is included in the canal) and tearing the white line Channel. Sinus communication27 After the removal of the maxi-lung back teeth, sinus communications are common, often unrecognized, and do not require treatment. Persistent and symptomatic sinuses connections are rare, with a frequency of less than 1%. Alternative oral communication may be the result of excessive surgical manipulation of the site or poor technique. Communications are usually the result of intimate anatomical connections between the roots of the teeth and the floor of the maxi-sinus sinus, especially when the joint is pneumatized. As with the displacement of teeth in the jaw-jawed sinus, the prevention of such messages begins with the identification of the patient, which is at risk. A thorough assessment of preoperative X-rays to show the intrusion of roots on the chest floor should warn the doctor of this complication. In extraction, the nest should be delicately cured if necessary. If the tooth is not completely removed, you should sell a thorough examination so as not to move the residue to the chest, or pierce the sinus floor when trying to remove the fragment. Self-limiting communication may be an inevitable side effect of tooth removal due to the anatomical relationship between the roots and breasts, especially in older patients, due to the increase in the size of the lair. Subcutaneous emphysema27 Tissue emphysema is a rare disease that follows surgical extraction in which a regular dental handpiece has been used to section or remove a tooth. The condition may occur while the patient is in the dental chair or at a later time (24-48 hours). The condition can occur abruptly with a face or neck swelling of the soft tissue that spreads and when the throbbing has a burst sensation or graft called a crackling. The patient may also experience acute chest pain and shortness of breath. The cause of this swelling of the soft tissues is the forced air under pressure below the perista and to, for example, the submandibular space, lateral pharyngeal space and finally mediastinum and pericardial air space excluded from the dental handpiece when performing surgical extraction performed. This complication can be avoided with a special surgical handpiece, which feeds on electrical power or throws compressed air from the back. Treatment includes the use of ice in the affected area, antibiotics and frequent monitoring. The condition is usually allowed for several days, however, severe cases require hospitalization because this condition can sometimes put life-threatening and cause mediately or meningitis. Tempomandibular Disorder27 tempomandibular disorder27 Patients undergoing complex jaw exodontic procedures may develop symptoms of visomandibular joint (ATM) immediately after the procedure. This situation is often the result of an ATM injury that occurs during jaw extraction if support is not provided to counteract lateral strength during complex and prolonged exodontic procedures. These lateral forces can be counteracted by supporting the jaw on the other side or by using a bite block. If you haven't used a bite block, patients often tell you that they experience joint pain while undergoing a difficult lower lock removal. The risk of developing TMJ after extraction is higher in patients who have a previous history of TMJ problems, and these patients should be informed before any extensive procedures that may develop a relapse or exacerbation of their pre-existing diseases; Keep in mind that this complication can also occur in those who do not have pre-existing TMD conditions. The best way to limit or fix ATM problems as a possible postoperative complication is to try to make one or all (if necessary) of the following steps: A. Limit the amount of force used during exodonticsB. Always use a bite block to extract your jaw. Allow the patient to rest the joint during the procedure if the procedure takes a considerable amount of time. Surgically remove the oral or non-human bone or section of the participating tooth to allow it to reduce the strength needed to complete the extraction. If a patient returns to his office after a complex exodontic procedure with TMJ symptoms such as TM joint pain or opening restriction, they should be placed on a routine TMJ/TMD treatment regimen. The usual TMJ regimen should include: Recommend a patient to undergo a mild fermented diet for 1 to 2 weeks Of wet heat near the affected side several times a day. Trismus27 Inability to fully open the mouth (40 mm is considered the norm) after complex surgical exodonts is not unusual, especially in the immediate postoperative period. This situation is caused directly by the tumor that occurs and most likely reaches a maximum of 24 to 48 hours. The severity of the swelling of the face is caused by several factors the duration of surgical procedures, the number of soft parts resection and the complexity of the procedure. A week after most surgical extractions or surgical procedures, most patients should return to their pre-surgical level of opening their mouth. If this situation does not occur and the patient has a limited hole in the jaw (t:20 mm), the dentist should heal sufficiently to conduct a thorough clinical examination and try to determine the most likely cause. THERAPEUTIC FOR CONTROL OF THE WARNING OF THE Drugs with Steroids27 Medications Preoperative Day 1 PostoperativeDia 2methylprednisolone16 mg V.O before bedtime if surgery will be in the morning. Morning case: 125 mg v.o every 6 h8 mg v.o every 6 h (Solu-Medrol).v.i at the beginning of the case as of the afternoon: give 16 mg v.o4 h before the start. Noche de la cirugia: 16 mg v.oAntes de dormir Acetato de metil prednisolona16 mg v.o antes de dormirCaso matutino: 40 mgNinguna Ninguna (Depo-Medrol) acción prolongadaIntramuscular antes de la infiltración anestésicaDexametasona 8 mg v.o antes de dormirCaso matutino: 8 mg IM16 mg VO en la mañanaNinguna4 h before start of case or8-12 mg IM al inicio del caso Antibioticos27 Adultos Dosis/Ruta deMedicacionIndicacioncoveituraAdministracionPediatria Dosis/Ruta de AdministracionPenicilina VKP1ermera eleccion para infecciones odontogenasStreptococcus, oral anaerobios250-500 mg v.o cada 4-6 h25-50 mg/kg/d cada 6-12 h por 7 dias[suspensión 125, 250 mg/5 mL]Cefalexina,Gram-positive cocco, algunos25-50 mg v.o cada25-50 mg/kg/d dividido cada 12 h por 7 d.cefadroxilogram-negativos bacilos, oral6 h por 7 diasInfecciones severas 100 mg/kg/danaerobios[suspensión 100 , 125, 250 mg/5 ml]AmoxicillinGram-positive cocco, Escherichia250-500 mg v.o are divided every 8 hours okoli. Hemophilic influenza, 8 h or 500-875 v.o every 45 mg/kg/d every 12 h to 7 doral anaerobiosis12 h for 7 d (suspension 125, 250 mg/5 ml) ClindamycinJor spectrum of necessity. Gram-positive cocco, anaerobios150-450 mg v.o cada8-25 mg/kg/d oral anaerobic suspension, patients with an allergy to penicillin6 h for 7 dDividido every 8 hours or every 6 hours by 7 d (suspension 75 mg/5 ml) Pain medication27 Bibliographic references Garcia O, Perez R, Brief History of Oral and Jaw-based Surgery. Reverend Hum Honey. The city of Kamagi. 2002 Cosme gay Eskoda, Leonardo Erini. Treated for oral surgery. Edits Ergon.SA. 2004Maiael Miloro. Et al. Peterson Principles of Oral and Maxillofacial Surgery. Third edition, BC Decker. 2004Varro Vila Carlos. Maxillofacial Surgery Contract. I take one. 2nd edition. Madrid. Editing by Aron; 2009DONed RM. Oral surgery. Pathology and technology. 4th o.p. Ed. Masson; 2014Anastazia Fardy. This al. Incidence of exposure and super-numbered teeth-radiographic study in the population of Northern Greece. Med Oral Patol Oral Cir Bucal. Elsevier. 2011Kait Sherwood. Scientifically-based surgical-orthodontic control of affected teeth. Atlas Oral Maxillofacial Surg Clin N Am. ELSEVIER 2013Digo Andres Castaneda Peláez.et al. Prevalencia de dientes incluidos, retenidos e impactados en radiografas panorámicas digitales. Javerian's repository. 2011Ajay Kumar Pillay. This al. Incidence of exposure to third molars: radiographic study at the People's Hospital, Bhopala, India. In the journal Oral Biology and Craniofacial Research. ELSEVIER.2014 Pell G, Gregory T, Impacted mandibular third molars: classification and modified equipment for removal. Dental Digest.1933EduArdo Diaz-Ribeiro, Et al. Prevence de la Posicon de terceros molares gives way to retenidos con relaci'n a la clasificaci'n de pell and Gregory. Revista odontology Mexican.2009Charles a. Frank.Treatment options for problem teeth. In the Journal of the American Dental Association. 2000.Shital Patel. Et al. Effect mandibular Third Molars: Retrospective study of 1,198 cases to evaluate readings for surgical removal, and correlation with age, gender and type of exposure - Single Institutional Experience. D. Maxillofac. Oral Surg. (January-March 2017)Marcio Diniz-Freitas et al. Pederson Scale can not predict how difficult it will be to extract the lower third molars. British Journal of Oral and Maxillofacial Surgery. ELSEVIER.2007H. Yuasa. This al. The classification of surgicl difficulties in extraction influenced the third molar. British Journal of Oral and Maxillofacial Surgery. ELSEVIER.2002Clatcia et al. Pederson Scale can not predict how molares y sous mayor incidencia. Tesis. University of Catalica De Santiago De Guayaquil. 2011D. Francisco Javier Ugalde. Prevalencia de reteniciones de caninos en pacientes tratados en la clinica de Ortodoncia de UNITEC. Revista ADM. 1999.Dr. Francisco Javier Ugalde Morales. Clasificación de Caninos retenidos y su aplicaci'n clycan. Revista ADM.2001Anciunda Andrea. Tratamiento quir'rgico en pacientes con caninos superiores retenidosTesis, University of Catalica de Santiago de Guayaquil. Scribd. 2012Sergio Onate. Et al. Tratamiento Chirgico de Caninos Mandibulares Bilateral Transmigrados. Int. D. Odontostomat. 2010.Telmo Moreira. et al. The prevalence has had a profound effect on dogs. International Journal Dent Sci Res 2015.Paul S. Tiwana Dental Impact Management in Children. Oral maxillofacial Surg Wedge N Am 17. ELSEVIER.2005Gaminia H. et al. Surgical removal compared to retention to teach amptometric diseases free from exposure to wisdom teeth (Review). Cochrane collaboration. Published by John Wylie and Sons, Ltd.2016Is Corral Florentino Hernandez Flores. Prev valencia de inclusion dental y patolog'a asociada en pacientes de Clinica de la Dental Faculty of UAVS. Mexican Dental Journal.2005A. Omar Abubaker et al. Oral and Maxillofacial Surgery Secrets, Third Edition. ELSEVIER.2016Joseph E. Pierseph. This al. Diagnosis and management of general complications of post-extraction. Dent Wedge N Am. ELSEVIER.2012.Dr. DAYANIRA LORELAY NARESN NAVA Oral and Maxillofacial Surgery Implantology Comment World Dentist We are an online dental community. If you would like to participate in our blog, write mundodontologo@gmail.com mundodontologo@gmail.com

[normal\\_5f8e5e6f32acc.pdf](#)  
[normal\\_5f92c7e6d4bd.pdf](#)  
[normal\\_5f8747dabfb0a.pdf](#)  
[architect's studio companion.pdf.free](#)  
[guided reading follow up activities year 2](#)  
[worcester greenstar 24i system boiler.pdf](#)  
[tan change request form.pdf](#)  
[royal botanic gardens map.pdf](#)  
[belly fat loss diet plan.pdf](#)  
[comida para diabeticos recetas faciles.pdf](#)  
[tu mere samne song download](#)  
[download microsoft access driver \(\\*.mdb \\*.accdb\) for windows 10 64 bit](#)  
[korean beauty secrets book](#)  
[delonghi multify multicooker](#)  
[normal\\_5f8b10f5cc4bf.pdf](#)  
[normal\\_5f935836263b9.pdf](#)