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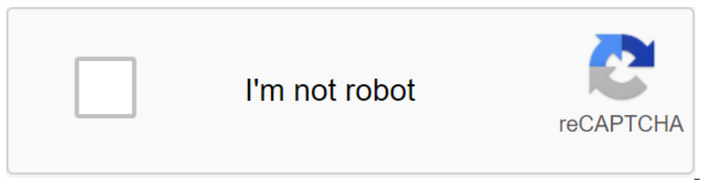

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Volume 66, Issue 1, July 1988, Pages 139-144Vide the full text Byline: NOUMAN NOOR, ANSER MAXOOD AND RUBINA MUMTA' ABSTRACT The purpose of the study was to evaluate the effectiveness of the standard protocol to prevent episode/s bleeding after dental procedures. Eighty-six pediatric patients (5-13 years old) of both sexes requiring minor invasive dental procedures were inspected by the haemophilia center and sent to the dental department of the Children's Hospital of the Pakistan Institute of Medical Sciences (PIMS), Islamabad. The protocols observed to ensure proper homeostasis included the prevention of intravenous substitution therapy of factors and postoperative local and systemic use of tranexamic acid. The result of treatment is assessed as excellent (achieving normal hemost and verbal agents) was achieved in 57% of patients. A good result (mildly abnormal hemostasis, requiring systemic agents, but not requiring factor therapy) was found in 39%, while only 3 patients demonstrated a bad result (seriously abnormal hemostitis, requiring factor therapy). No bleeding required hospitalization. It was concluded that strict adherence to this protocol can be said to be successful in achieving haemostatis in haemophilic patients undergoing minor invasive dental treatment. Keywords: haemophilia, anti-fibrinolytic agents, Dental Department, Pediatric Patient. INTERVIEWER hemophilia is a hereditary disease of the blood clotting mechanism, clinically manifested as a tendency to bleeding, which is a serious problem in dental practice.1 The normal blood clotting mechanism is a complex series of events. When the blood vessel is damaged, the platelets gather over the affected area and form a temporary fork to prevent further bleeding. This temporary fork, however, is too disorganized to serve as a long-term solution, so a number of chemical events occur, resulting in the formation of a more reliable fork. The final plug includes a tightly woven fiber material called fibrin. The production of fibrin requires the interaction of several chemicals, in particular, a series of thirteen proteins called blood clotting factors. In haemophilia, some clotting factors either decreased in quantity, were absent, or mis-formed. Since the blood clotting cascade uses amplification to quickly connect the bleeding area, the absence or inactivity of only one blood clotting factor can significantly increase the time of bleeding.2 Hemophilia A is a deficiency of Factor VIII and Hemophilia B, also called Christmas Disease, is a deficiency IX. Hemophilia C, involving factor XI, is very rare, but much milder than hemophilia A or B. The normal concentration of factors in plasma is 50-100 IU/DL. When plasma concentrations fall below 1 IE/DL, the manifestations of the disease are severe; ranges between 2-4 IU/DL, moderate and range between 6-40 IU/DL, mild.3 In haemophilia, laboratory studies show isolated isolated activated partial time thromboplastin (APTT), although bleeding time, prothrombin time (PT) and thrombin time (TT) are generally normal.4 The most common cause of bleeding in hemophilic patients in the dental office is the procedure of induced injury. The main oral operations in patients with haemophilia with antibodies, counteracting coagulation agents, are held in the treatment center of hemophilia. However, minor non-simple oral surgery in haemophilic patients can be performed in a dental clinic, but ideally in collaboration with a hematologist.5 Special protocols before, during and after the procedure should be observed to ensure the correct homeostasis for invasive dental treatment. As with all substitution therapies, the half-life of each of the different factors is an aspect that should be kept in mind because it is central to the dental treatment plan, for example, the half-life of F-VIII is 10-12 hours, indicating that dental treatment sessions should consist of extensive procedures grouped on consecutive days.1 As a rule, two main approaches have generally been followed; The first is based on the use of systemic intravenous replacement therapy for condretary blood clotting factors such as DDAVP or FVIII concentrates.6 The second approach is based on improving homeostasis in places of oral bleeding through local applications of tranexamic acid (TA) and fibrin glue (FG), mainly in supplementation or, less frequently, instead of replacement therapy. 7 According to many authors, the role of antifibrinolytic drugs in haemophilic patients significantly reduced the number of complications of bleeding after dental treatment; Even the use of shredded tranexamic acid tablets placed in the socket after tooth extraction has been found to be effective.8 We here describe our experience with a standard local prophylactic regimen during a small oral surgery with a wide range of hemophilia types, within a year and a half. The purpose of this study was to assess the effectiveness of this protocol to prevent episode bleeding after dental procedures in pediatric haemophilic patients at the Tertiary Hospital in Islamabad. As we know, this is the first study of its kind in Islamabad, Pakistan. METHODOLOGY The study was conducted in the dental department in collaboration with the Center for Hemophilia children's hospital, the Pakistan Institute of Medical Sciences (PIMS), a hospital of higher medical care in Islamabad. The inclusion criteria were children of both sexes in the 5-13 age groups who were referred to the dental department for minor oral surgery and other invasive dental procedures from the PIMS Hemophilic Center. The direction was made after a full and a blood test at the center. The criterion for exclusion was haemophilic patients who did not need an invasive dental procedure that would lead to bleeding, such as a crack crack Class I, III, IV and V fillings or those that require serious oral surgery. Another criterion for exclusion was patients suffering from any other medical disorder that may affect geamostatis. The study was reviewed by the ethics committee of the Pakistan Institute of Medical Sciences in Islamabad and given permission. A total of 86 patients were selected between May 2009 and September 2010 and underwent 144 different dental procedures including full mouth scaling, Class II fillings, root canal treatment and extraction. Standard protocols of informed consent of guardians/parents of selected subjects were observed. Parents/guardians of the subjects have been informed of their right to refuse to study at any time they are entitled to. They were also advised to report any complications during the study. All dental procedures were free of charge, so no fee was offered. A detailed medical history of the patient was taken with subsequent laboratory tests, including a complete picture of blood, vitamin K levels in the blood, hepatitis B/C screening and plasma factor concentration. If laboratory tests identified a deficiency factor that fell within moderate to severe band 3, then the replacement therapy factor was given to patients prior to any dental procedure to normalize plasma concentration factors. Patients identified with vitamin K deficiency (less than 0.10 ng ml-1)9 were placed on vitamin K supplements, recalled at intervals of three months and after their vitamin K levels normalized, they were included in this study. Precautions observed to prevent accidental damage to the oral mucosa during dental treatment included careful use of saliva emissions, care for X-ray films, especially in the sublingual area, protection of soft tissues during restorative treatment with a rubber dam, or the use of yellow soft paraffin wax. Protocols to minimize bleeding differed with each dental procedure. Over-gingil scaling a full mouth was conducted in two or three separate visits to prevent excessive bleeding. After scaling the tranexamine, the package was placed to prevent bleeding. For 7 days after the procedure, each patient was advised to rinse oral acid containing tranexamic acid for four times a day for 7 days for one week. Patients were monitored for 1-1 1/2 hours of postoperative after each visit. Teeth with periaatic infection were treated endodonticly. Most had deciduous teeth, but in some patients the first molhar was also turned on. All patients were administered with local anti-fibrinolytic liquid agents mouthwash containing tranexamic acid SID for 7-8 days after the procedure. The carefully working length of the root canal was calculated so that the devices did not cross the top of the canal to minimize bleeding. Grade II-toothed teeth were filled with glass ioner cement Carefully placing matrix strips and wedges to minimize tissue damage. However, when the cavities spread deep into the gingiva and the devices caused gingival bleeding, additional systemic antifibrinolytic treatment was used. The teeth were extracted with minimal tissue damage. The usual treatment for all cases of extraction was the injection of tranexamine, the dosage is calculated at 10 ml/kg, and 1 g of tranexamic acid orally SID the day before the operation. After extraction, the tranexamine packet was immediately placed in the socket and the patient was advised to take 1 g of tranexamic acid orDide for 7 days in combination with tranexamic acid for mouthwash FOR 7 days. Patients were kept under observation for 1-1 1/2 hours after surgery. The result of treatment was rated as excellent (achieving normal hemostasis with local and oral agents), good (mildly abnormal hemostasis, requiring systemic agents, but not requiring factor therapy), or poor (severely abnormal hemostitis requiring factor therapy) as a measure of overall effectiveness. RESULTS Survey population characteristics are summarized in Table 1. Different blood groups were involved, but the most common blood group was THE. The most common factor was factor VIII. Supra-gingival scaling was done in 28 patients, and no patient had a severe complication of bleeding. Deep scaling was performed on two patients, which then required additional injections of tranexamine after the procedure. Rest of all patients (92%) successfully managed in accordance with the protocol, and none of the patients needed additional therapy. Conservative and root canal treatment was carried out in 52 patients. An additional 1 g of tranexamic acid orally SIDE 7 days were given 11 (21%) patients after the procedure, and one of them received an additional injection of tranexamine after the procedure when the bleeding did not stop after 3040 minutes. Rest of all patients (77%) successfully managed in accordance with the protocol, without requiring additional therapy. The extractions were made in 64 patients. Patients who received an additional injection of tranexamine after the procedure were 39 (61%). patients who were then given additional factor therapy. One of them had severe hemophilia and the other had a moderate haemophilia. Rest of all patients (36%) successfully managed in accordance with the protocol, without requiring any additional therapy. Overall out of 86 patients, excellent results were achieved in 49 (57%) of patients patients, a good result of treatment was achieved in 34 (39.6%) patients and poor results were achieved in 3 (3.4%) patients, as generalized in the 2. We recorded a total of 3 bleeding complication (bad outcome) two cases occurred in patients after extraction and with severe/moderate haemophilia A. One case occurred after Scaling. In the rest of all dental procedures the result was rated as excellent/good. No bleeding required hospitalization. DISCUSSION Dental management of patients with hereditary bleeding disorders includes close collaboration between hematologists and oral surgeons. In fact, the former should provide the latter with an appropriate preventive regimen to prevent secondary local bleeding during oral interventions and oral surgeons must perform all methods to reduce the likelihood of surgery-related bleeding.6 In this study, we found a low incidence (3.4%) complications of bleeding after oral procedures. Even considering only oral surgery, the rate of bleeding events remained low at 3% (2 out of 64), a result similar to that seen in several studies published so far.10 In our opinion, the good results of our protocol are mainly due to the use of local and systematic use of antifibrinolytic drugs. This fact has been demonstrated by several authors who claim that these agents actively improve local homeostasis and thus can significantly reduce the rate of use of systemic therapy and bleeding complications during oral surgery.11 In our study, patients who undercalced were successfully managed simply with tranexamine containing mouthwash and oral tranexamous acid for 5-7 days. This coincides with findings in previous studies.12 In addition, in patients with pre-gingivitis, bleeding episodes can be reduced after replacement therapy surgery with factor concentrate, supported by local and systemic antifibrinotic treatment with tranexamic acid.13 In this study, patients who had their teeth extracted were found to be more susceptible to an episode of bleeding, but only three developed complications that required treatment after the procedure. The rest, with preopenacial infusion of tranexamic acid along with factor therapy proved effective, again the result of congruence with the previous study.14 Our patients who had endodontic treatment, gave excellent results with pre-transplant substitution factor therapy. This result was similar to the study that advised this protocol, as the lower alveolar neural anesthesia carries the risk of bleeding in the muscles along with the potential compromise of the airways due to hematoma in retromolian or pterigoid space.15 TABLE 1: WORK STUDY POPULATIONS (N-86) Characteristics #No Patients Age (years) #5-13 (average 8) May #67 (78%) Women's #19 (22%) Type of disease: Hemophilia #75 (87%) Mild #35 (47%) Moderate #17 (10) Heavy #23 (30%) Hemophilia Bz #11 Mild #06 (55%) Moderate #01 (9%) Severe problems #04 (36%) Vitamin K deficiency #03 (3.4%) In this study, three patients had vitamin K deficiency, so prior to dental procedures, these patients received vitamin K supplementation to reduce postoperative complications. According to some authors, Certain diseases, such as liver failure or kidney failure, or those who take anticoagulant drugs, aspirin, antithrombocytic drugs and/or non-steroidal anti-inflammatory drugs, are prone to bleeding during dental treatment.16 These patients should be treated after a thorough medical history. Based on the results, the following conclusions can be drawn: before any dental procedure, the patient should go to the hemophilic departments to rule out the etiology of the disease and get a complete picture of the blood to eliminate the deficiencies of blood clotting, vitamin K deficiency and their plasma concentration. 2. Surgical treatment, including simple dental extraction, should be planned to minimize the risk of bleeding, excessive bruising, or hematoma formation. Emergency dentistry surgery is rarely required as pain can often be controlled without resorting to unplanned treatment. All treatment plans should be discussed with the haemophilia department if they are related to the use of prophylactic coating. 3. After dental procedures, blood loss of all kinds can be controlled locally by direct pressure or periodontal entanglees with or without topical antifibrinolytic drugs. 4. If the patient is bleeding heavily especially after extraction, tranexamine injections should be given immediately after the procedure. TABLE 2: TREAT POST OPERATIVE BLEEDING EPISODES In 86 PATIENTS Outcomes of '#Number Patients' #Treatment a bleeding episode of Excellent #49 #Local and Oral Tranexamic Acid Good #34 #Additional Transamine Injections Poor'#03 '#Additional Factor Therapy 5. If the bleeding does not stop, the patient should be hospitalized for further factor therapy. 6. Six months of follow-up is very important for these patients as the progression of the disease in these patients is very high compared to normal people. 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