RICHMOND
ENDODONTIC CENTRE

DX HORRIBILIS

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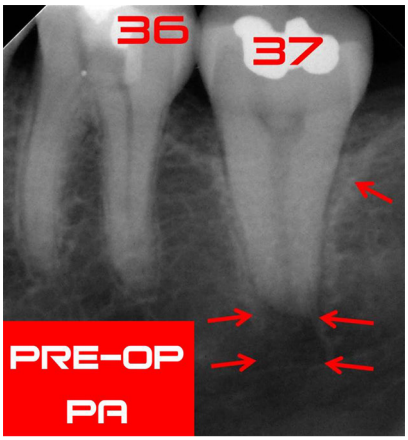

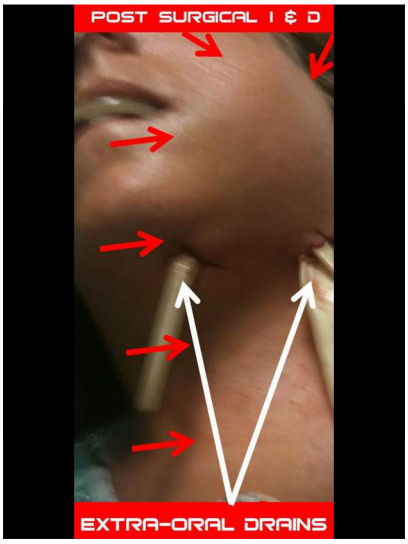

This case demonstrates how things can cascade out of control for what, upon first glance, appears to be innocuous. A thirty-something gentleman reports vague pain in quadrant three. The medical/dental histories are unremarkable save a car accident ten years ago that required extensive restoration of many teeth. There were no overt signs of infection or other problems. The dentist reports pulp and periradicular testing revealed 36 as the culprit. The pulpectomy was uneventful and Tylenol No. 3 was prescribed. Nevertheless, over the proceeding days and weeks things deteriorated to such an extent the fellow spent ten days in ICU:

- **Post-Op Day 2:** Saturday emergency appointment at the dental office. The patient (pt) reports extreme pain to bite, it also woke him from sleep and caused him to vomit. Pain now extends to the midline and the pt suspects the 37 is the hellion. The bite of 36 was adjusted.
- **Day 3:** Pain is so severe the pt is sweating and cannot sleep; Amoxicillin and Ibuprofen (600mg) phoned in by the dentist. Pt ended up going to ER twice that night and after an argy-bargy an injection of Demerol was reluctantly provided.
- **Day 4:** Percocet prescribed by the dentist.
- **Day 5:** Pt has limited opening with buccal fascial space involvement, the chest has a red rash. Tissue around 37 is swollen with pus draining from the sulcus; this was incised and drained by the dentist. Amoxicillin replaced with Clindamycin.
- **Day 9:** Fascial space involvement partially abated; 37 is mobile, 36 is not. Dentist incised and drained swelling buccal to 36. Amoxicillin, Metronidazole, and Percocet prescribed.
- **Day 10:** Pt reports swelling getting worse and is now experiencing tingling and numbness of lower left lip. Uneventful extraction of 37 by the dentist.
- **Day 23:** Fascial space involvement has returned with severe trismus; pt unable to open jaw >5mm. Hospital provides IV Clindamycin; CT and ultrasound reveal no osseous lesion within the mandible but adenopathy is present in the neck. A 2.7cm diameter accumulation of fluid present in the masseteric, buccal, and pharyngeal spaces. Twice over two days, extra-oral incision and drainage performed with general anaesthesia at the hospital.
- **Day 33:** Pt discharged from ICU, four weeks of post-op IV antibiotics and various oral meds provided.

There are a litany of lessons that can be gleaned from this case. Generally speaking, whenever a response to endodontic treatment or extraction is suboptimal, be wary and consider further radiographic investigations (i.e. CBCT, angled PA's) and second opinions from colleagues or specialists. Post-op fascial space involvement, numbness, vomiting, sleep disruption, and the like are serious sequelae warranting a comprehensive re-evaluation of the diagnosis and treatment to-date. A delay in an accurate diagnosis and decisive treatment can have dire consequences.

Complacency is the antagonist of competency. The general dentist in this case may feel unfortunate to have been involved with this case. However, I submit she was extraordinarily lucky this patient recovered fully and did not seek recompense with the College. Rare things occur rarely, but I am reminded of this case each time a patient reports an atypical response to treatment.

Regards,

Lest We Forget N'oublions jamais

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