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ABSTRACT BOOK

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Emergency dental care for patients with systemic connective tissue diseases

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Introduction: Introduction: Systemic connective tissue diseases (SCTDs), including rheumatoid arthritis (RA), systemic lupus erythematosus (SLE), systemic sclerosis (SSc), and dermatomyositis, are associated with oral tissue involvement and an increased risk of dental complications. These patients frequently develop acute inflammatory processes in the maxillofacial region, as well as atrophic and erosive-ulcerative lesions of the oral mucosa, and exacerbations of periodontal diseases, which complicate emergency dental care.

Aim: To optimize approaches to emergency dental care for patients with SCTDs, considering their immune status, specific concomitant therapy, and potential risks of complications, in order to enhance treatment effectiveness and safety.

Materials and methods: The protocols of emergency dental care in patients with SCTDs were analyzed, along with clinical cases of acute dental conditions and their management considering comorbidities. Special attention was given to the use of anesthesia, anti-inflammatory and antibacterial therapy, physiotherapy methods, and postoperative management.

Results: The management of emergency dental care in patients with SCTDs requires a comprehensive approach, including pain and inflammation relief, minimizing invasive procedures in cases of osteonecrosis, rapid drainage in infectious complications, antibacterial prophylaxis, and rheumatologist consultation before surgical interventions. Careful selection of anesthesia is essential, as vasoconstrictors can elevate the risk of cardiovascular complications. The optimal choice is anesthetics with minimal vasoconstrictor content, such as 3% mepivacaine or 4% articaine without a vasoconstrictor.

In patients receiving bisphosphonates, traumatic interventions should be avoided due to the risk of osteonecrosis. Preoperative additional diagnostics (CBCT) and antibacterial prophylaxis are recommended.

In cases of acute inflammatory conditions affecting the maxillofacial region (periodontal abscess, periostitis, phlegmon, etc.), prompt drainage and antibacterial therapy, considering microbial sensitivity, are necessary. Surgical interventions should be minimally traumatic, utilizing laser or ozone therapy.

The treatment of erosive-ulcerative lesions of the oral mucosa (in SLE, SSc, RA) includes the application of local anesthetics and anti-inflammatory agents to alleviate pain and reduce inflammation, the use of keratoplastics to stimulate tissue regeneration, antibacterial therapy in cases of secondary infection, as well as physiotherapeutic methods. Patients with immunosuppression (SLE, dermatomyositis, RA on biological therapy) require antibacterial prophylaxis before invasive procedures. The optimal choice is amoxicillin or clindamycin in case of β-lactam allergy. Long-term glucocorticoid therapy may necessitate steroid background adjustment to prevent adrenal crisis.

The interaction of nonsteroidal anti-inflammatory drugs with the baseline therapy of SCTDs should be considered, especially in patients with SLE or RA. An alternative is selective COX-2 inhibitors combined with gastroprotective agents.

Postoperative control involves regular monitoring of the healing process, early detection of complications, and adjustment of medication therapy in collaboration with a rheumatologist. During remission, thorough sanitation of odontogenic infection foci and prevention of their occurrence are necessary.

Conclusions: Patients with SCTDs require a specialized approach to emergency dental care due to an increased risk of complications. Optimizing local anesthesia, antibacterial therapy, and minimally invasive techniques significantly enhances treatment outcomes. A multidisciplinary approach is crucial for enhancing treatment effectiveness, minimizing complications, and enhancing patients' quality of life.

Key words: connective tissue disorders, oral complications, dental emergencies, anesthesia selection, antibacterial prophylaxis, postoperative management, rheumatology collaboration