Antibiotics in Odontogenic Infections - An Update

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Abstract

Odontogenic infection is an infection that originates within a tooth or in the closely surrounding tissues and can extend beyond natural barriers and result in potentially life-threatening complications. Spreading dental infections are routinely managed by endodontic or surgical intervention. Antibiotic therapy is aimed as a supportive measure for controlling the spread of infection and should be used judiciously. Proper understanding of disease process, oral and periapical microorganisms and pharmacokinetics is essential to prevent the overuse of antibiotics in dentistry.

Keywords: Odontogenic infections; Antibiotic

Introduction

Odontogenic infections are among the most common infections of the oral cavity. They can be caused by the sequelae of dental caries, periodontal disease or due to trauma. Early recognition and management of acute orofacial infections is critical, because of rapid systemic involvement. Odontogenic infections can lead to complications such as osteoperiostitis of the jaw, osteomyelitis, and deep fascial space infections [1,2]. Odontogenic infections are typically polymicrobial in nature. It may be due to the fact that the oral cavity contains a complex population of microorganisms. However, the anaerobes generally outnumber the aerobic bacteria by a factor of three to four folds [3].

Although bacteria play a major role in odontogenic infections, antimicrobials are not always warranted. Antibiotics in Dentistry are used for therapeutic and prophylactic reasons [4]. Therapeutic antibiotics are advised to treat infections in the oral cavity after local debridement has failed, whereas Prophylactic antibiotics are given to prevent diseases caused by oral flora, introduced to distant sites, which puts the host at risk. The antibiotics are advised depending upon the severity of the infection, patient's immune defense status, in case of acute infection, if inflammation is moderate and the process has progressed rapidly, in cases of diffuse cellulitis with moderate-to-severe pain, or if the patient has signs of bacteremia, Antibiotics are also advised in medically compromised individuals, and in cases of trauma where the tooth has been reimplanted [5-7].

A draining abscess or a fistula containing a chronic infection usually requires only root canal treatment or extraction. However, other disease processes, including periodontal abscesses, pericoronitis, acute periapical abscesses and deep fascial space infections may require antimicrobial therapy. Antimicrobials must never be used as a replacement for appropriate surgical drainage and/or debridement, and should only be used as adjunctive therapy [1,2,7]. If Antimicrobial therapy is advised soon after diagnosis and before surgery, it can shorten the period of infection and minimize associated risks such as bacteremia [8].

Choice of Antibiotics

Several antibiotics are indicated for odontogenic infections. Proper understanding of disease process, treatment plan, mode of action of antibiotics (Table 1), patients health status, and pharmacokinetics and dose (Table 2) of the antibiotics is essential for a successful treatment outcome. The orally administered antibiotics are effective against odontogenic infections. They include amoxicillin, metronidazole, clindamycin etc.

Penicillin has been considered as first-line drug for odontogenic infections. Amoxicillin, semi synthetic penicillin is the drug of choice in treating dental infections and is the most common antibiotic used by dentists. If a patient with an early stage odontogenic infection does not respond to Amoxicillin, there is a strong probability of the presence of resistant bacteria. Bacterial resistance to penicillins is mostly as a result of the production of beta-lactamase by the bacteria. Whereas alteration of the target protein, enzymatic inactivation of the drug, bypassing of the target, preventing drug access to targets also can lead to resistance. In penicillin resistant cases beta-lactamase-stable antibiotics should be prescribed to the patient. These include either clindamycin or amoxicillin with clavulanic acid [1,9,10]. The American Heart Association considers amoxicillin to be the first choice for

<table>
<thead>
<tr>
<th>Antibiotic</th>
<th>Mode of action</th>
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<tbody>
<tr>
<td>Amoxicillin</td>
<td>Inhibition of cell wall biosynthesis that leads to the death of the bacteria.</td>
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<tr>
<td>Metronidazole</td>
<td>Inhibits nucleic acid synthesis by disrupting the DNA of microbial cells</td>
</tr>
<tr>
<td>Cephalosporins</td>
<td>Inhibition of cell wall biosynthesis</td>
</tr>
<tr>
<td>Clindamycin</td>
<td>Inhibits bacterial protein synthesis and is bactericidal at high dosages</td>
</tr>
<tr>
<td>Fluoroquinolones</td>
<td>Interfere with bacterial DNA metabolism by inhibiting the enzyme topoisomerase</td>
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<table>
<thead>
<tr>
<th>Antibiotics</th>
<th>Adults</th>
<th>Children</th>
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<tbody>
<tr>
<td>Amoxicillin</td>
<td>250-500 mg every 8 hours</td>
<td>20-40 mg/kg/day in divided doses every 8 hours</td>
</tr>
<tr>
<td>clindamycin</td>
<td>150-450 mg every 6 hours (maximum 1.8 g/day)</td>
<td>8-20 mg/kg/day in 3-4 divided doses</td>
</tr>
<tr>
<td>Metranidazole</td>
<td>7.5 mg/kg every 6 hours (maximum 4 g/24 hours)</td>
<td>30 mg/kg/day in divided doses every 6 hours</td>
</tr>
<tr>
<td>Amoxicillin with Clavulanic acid</td>
<td>500-875 mg every 12 hours</td>
<td>25-45 mg/kg/day in doses divided every 12 hours</td>
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arthropathy noticed in weight bearing joints. Due to the spectrum and fluoroquinolones in pediatric patients has been limited due to activity against gram positive bacteria is poor. The use of ciprofloxacin prophylaxis [13].

than erythromycin, to penicillin-allergic patients requiring endocarditis [1]. The American Heart Association recommends clindamycin, rather clindamycin as the drug of choice in treating odontogenic infections [1]. It drug guides to Antimicrobial Therapy to replace penicillin V with efficacy in preventing dry socket [16]. Clindamycin's broad spectrum of action. Its efficacy in treating odontogenic infections is comparable to Penicillins [1], It growing children can cause enamel defects in children [14].

Tetracycline because of its side effects and widespread resistance is not commonly used to treat odontogenic infections. Newer drugs like Doxycycline and minocycline possess better anaerobic activity than tetracycline, but they should not be considered first-line therapy for odontogenic infections. Use of tetracycline in pregnant women and growing children can cause enamel defects in children [14].

Clindamycin has excellent broad spectrum of action. Its efficacy in treating odontogenic infections is comparable to Penicillins [1]. It has been used successfully to treat patients when therapy with other agents has failed [15]. Several studies have demonstrated clindamycin's efficacy in preventing dry socket [16]. Clindamycin's broad spectrum of coverage with excellent clinical efficacy has prompted some standard drug guides to Antimicrobial Therapy to replace penicillin V with clindamycin as the drug of choice in treating odontogenic infections [1]. The American Heart Association recommends clindamycin, rather than erythromycin, to penicillin-allergic patients requiring endocarditis prophylaxis [13].

The drugs ciprofloxacin, norfloxacin, ofloxacin, and levofloxacin are bactericidal and have potent gram negative activity. But their activity against gram positive bacteria is poor. The use of ciprofloxacin and fluoroquinolones in pediatric patients has been limited due to arthropathy noticed in weight bearing joints. Due to the spectrum of organisms associated with odontogenic infections, the use of fluoroquinolones in the treatment of acute odontogenic infections should not be considered [1,17]. Moxifloxacin, a fourth generation fluoroquinolones has the highest rate of bacterial susceptibility among all antibiotics including penicillin and clindamycin for odontogenic infections. However, given its broad spectrum and high cost, it can be only considered as a second line therapy to penicillin V, metronidazole and clindamycin [18,19].

Antibiotic Concerns

As there is no clear guideline for use of antibiotics in dentistry, it has been misused or overused in most of the cases; therefore, antibiotic resistance is increasing [4]. The use of cephalosporins in patients with penicillin allergy was a cause of concern in the old literature, but latest studies show that there is only limited correlation between penicillin allergy to cephalosporin antibiotic. Most cross reactivity between penicillins and cephalosporins is because of the similarity of R1 side chains. Latest literature shows cross reactivity between penicillins and most second- and all third- and fourth-generation cephalosporins is negligible. The cross reactivity between penicillins and cephalosporins in individuals who report a penicillin allergy is approximately 1% and, in those with a confirmed penicillin allergy, 2.55% therefore if a patient is having an allergic response to penicillin, it is safe to administer a cephalosporin with a side chain that is structurally dissimilar to that of the penicillin or to administer a third- or fourth-generation cephalosporin [20].

Antibiotics should be used only for the management of active infection or to prevent the potential spread of infection. However, intravenous antibiotics and hospital admission should be strongly considered when swelling of the airway, swelling of the eyelid, or neck involvement is present, or the patient's level of activity and oral intake is decreased [7]. The routine use of antibiotics before or after extractions or endodontics is questionable. Therefore, routine prescription of antibiotics for every extraction or endodontic procedure must be any potential benefit [8].

Conclusion

Antibiotics are essential for control of odontogenic infections even though mechanical debridement of pulp tissues is necessary. It should be used judiciously and have to be limited for conditions which are really indicated. Amoxycillin continues to be the drug of choice. Proper understanding of disease process, microbiology of odontogenic infection and pharmacokinetics of the antibiotics is essential for successful therapy.

References


Table 3: Antibiotic prophylaxis for endocarditis and joint replacement therapies.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Agent</th>
<th>Adults</th>
<th>Children</th>
</tr>
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<tbody>
<tr>
<td>Oral</td>
<td>Amoxicillin</td>
<td>2 g</td>
<td>50 mg/kg</td>
</tr>
<tr>
<td>Unable to take Oral Medication</td>
<td>Ampicillin or Cefazolin or Ceftriaxone</td>
<td>2 g IM* or IV†</td>
<td>50 mg/kg IM or IV</td>
</tr>
<tr>
<td>Allergic to penicillins (oral)</td>
<td>Cephalaxin or Clindamycin or Azithromycin or Clarithromycin</td>
<td>2 g</td>
<td>50 mg/kg</td>
</tr>
<tr>
<td>(unable to take oral medication)</td>
<td>Cefpodoxime or Clindamycin</td>
<td>600 mg or 500 mg IM or IV</td>
<td>20 mg/kg IM or IV</td>
</tr>
</tbody>
</table>

IM- Intramuscular; IV - Intravenous


