'I learnt about Dentistry from that'

Readers are encouraged to submit clinical experiences, good and bad, in a culture of open reporting, so that other clinicians will learn from these experiences. Unlike articles in *Dental Update*, in which published articles are peer reviewed by two experts in the field of the article, this page is not subjected to review other than by the Editorial Director.

A male patient in his mid 50s attended for routine extraction of the UL3. His medical history included: diabetes; MRSA-related skin infections; and arthritis. He transferred from his wheelchair to the dental chair. I extracted the UL3, haemostasis was observed, and post-operative instructions were given. The patient transferred back to his wheelchair and left the surgery.

The following morning the patient's wife called the practice saying that the patient was unwell and had a swelling which had closed his eye. However, I was working elsewhere and did not receive the message until later. I called back as soon as I heard, but was told that he was very unwell and semi-conscious. I rang 999 and requested an ambulance, explaining that there was a serious problem. I then phoned the Oral Surgery Department, explaining the situation, and requested them to attend at A&E.

The patient was admitted through A&E direct to ICU. I attended at ICU immediately after afternoon surgery and was told that the patient was unconscious and was receiving IV antibiotics. I met with the patient's wife and explained that this was an extremely unusual extreme infection subsequent to the extraction. She was very distressed.

The patient remained in ICU for 8 days. I spoke with the ICU consultant each day and relayed information to his wife and arranged for flowers and a card to be delivered from our staff. Fortunately, the patient made a full recovery.

I am pleased to say he returned to the surgery for further treatment. He thanked me for all the kindness to his wife whilst he had been in hospital. But he remarked that a friend had told him he could sue me for 'a lot of money' but of course he would not consider doing anything like that.

What I learnt from this was:

1. Diabetic patients, especially those with MRSA infections, are more likely to have post-operative infection after extraction due to their immunocompromised status and should be warned pre-operatively.
2. Kindness and consideration to the family was appreciated and was possibly part of the reason that there were no subsequent complaints or litigation.

I attended a male patient in his mid 70s on a domiciliary basis in his nursing facility. He had a medical history of dementia, but nothing else was recorded. Nursing staff had requested the visit as he had a sinus in his right cheek from which pus was draining. He had had numerous courses of antibiotics prescribed by the doctor but the sinus had not resolved. A dental foundation trainee had also attended and had also prescribed antibiotics.

Upon examination he was a cheerful, if very confused gentleman. He was assessed as lacking capacity to give consent. Extra-oral examination showed a draining chronic sinus of the cheek (adjacent to the LR6). Intra-oral examination showed a grossly decayed LR6, decayed to the cervical margin.

His daughter was consulted and it was agreed that it was in the patient's best interests to have the tooth extracted and the appropriate consent form completed. The LR6 was extracted under local anaesthetic uneventfully. Upon review a week later the sinus was healing, but his cheek remained puckered and there was scarring. A month later the cheek remained much the same as before.

Unfortunately, I had not put the scarring down as a potential complication on the original consent form. His daughter was upset that the patient's facial appearance had not improved and complained directly to me. After a difficult conversation she was able to accept that the management of elder patients with dementia was difficult; scarring was a recognized complication after resolution of such a chronic condition; and that it would be inappropriate to provide surgical revision to improve the cosmetic appearance. (Life expectancy of patients in care facilities is approximately 6 months).

From this I appreciated that:

1. There is no age when cosmetic/aesthetic results are unimportant.
2. Sometimes one has to 'take one for the team', as the reason there was residual scarring was that both medical and dental colleagues had not previously managed the problem appropriately.