

Management of the child in pain



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Today

- ▶ Interaction
- ▶ Participation
- ▶ Communication



Learning Outcomes

- ▶ Understand the causes of pain in paediatric patient
- ▶ Recognise signs and clinical presentations of child in pain
- ▶ Discuss treatment options for children in pain
- ▶ Have an awareness of how to manage co-operative and non-cooperative children in pain
- ▶ Understand other factors involved in treating children

What is a child?



England

▶ In England a child is defined as anyone who has not yet reached their 18th birthday. Child protection guidance points out that even if a child has reached 16 years of age and is: living independently, in further education, a member of the armed forces, in hospital; or in custody in the secure estate they are still legally children and should be given the same protection and entitlements as any other child (Department for Education, 2018a).

Northern Ireland

▶ In Northern Ireland the [The Children \(Northern Ireland\) Order 1995](#) defines a 'child' as a person under the age of 18.

Scotland

▶ In Scotland, the definition of a child varies in different legal contexts, but statutory guidance which supports the [Children and Young People \(Scotland\) Act 2014](#), includes all children and young people up to the age of 18.

▶ Where a young person between the age of 16 and 18 requires support and protection, services will need to consider which legal framework best fits each persons' needs and circumstances. The [National guidance for child protection in Scotland](#) gives more detail about this and explains how professionals should act to protect young people from harm in different circumstances (Scottish Government, 2021).

Wales

▶ Section 3 of the [Social Services and Well-being \(Wales\) Act 2014](#) states that a child is a person who is aged under 18.

Treating children



Treating children

- ▶ Difficult
 - ▶ Challenging
 - ▶ Small mouth
 - ▶ Exhausting
 - ▶ Brings me out in sweat
 - ▶ Makes me nervous
 - ▶ Glad to see them go out of the surgery
 - ▶ I don't mind the children... it's the parents!!
- ▶ Easy
 - ▶ Fun
 - ▶ Rewarding
 - ▶ Enjoyable
 - ▶ No pressure



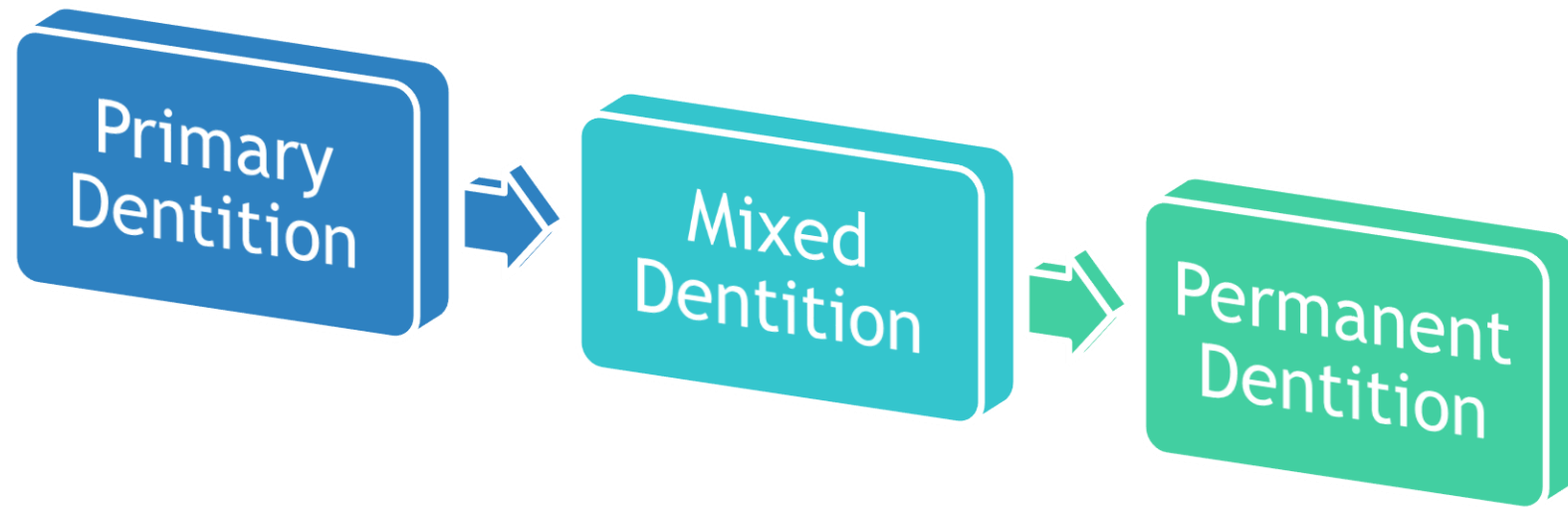
Number of Children registered with GDP

2005	271,827
2006	270,263
2007	267,982
2008	264,642
2009	272,122
2010	273,575
2011	300,113
2012	317,310
2013	318,522
2014	319,614
2015	316,440
2016	318,860
2017	322,499
2018	326,714
2019	329,491
2020	331,566
2021	321,026
2022	320,286
2023	331,903
2024	330,078
2025	301,926

Registration Rate
for children in
Northern Ireland
is 69%

Annual Dental Statistics released by
BSO

In Dental Terms a Child can mean



How to manage child in pain



Causes of dental pain in child



Causes of dental pain in child

- ▶ Reversible pulpitis
- ▶ Irreversible pulpitis
- ▶ Trauma
- ▶ Post treatment pain (extraction/restoration)
- ▶ Food packing
- ▶ Mouth Ulcers
- ▶ Wobbly tooth
- ▶ Sensitivity from toothwear
- ▶ TMJ/clenching/grinding
- ▶ Perio problems
- ▶ Discomfort from erupting tooth
- ▶ Lumps and bumps

Signs and symptoms of child in pain



Pulpal Diagnoses

Reversible pulpitis

- Intermittent sharp pain
- Difficult to localise
- Triggered by sweet, cold or hot stimulus
- Upon removal of stimulus, pain ceases fairly quickly
- Pain relief helps
- Not TTP, +ve ept (at a low current), painful to e.c

Irreversible pulpitis

- Prolonged and sometimes constant throbbing pain
- Localised to tooth
- Hot stimulus worsens pain, may come on spontaneously
- Pain relief doesn't help much
- Night wakening
- Referred pain
- TTP (+ve ept at a higher current)
-ve to e.c.

Pulpal Diagnoses

▶ **Pulpal Necrosis**

- asymptomatic
- -ve ethyl chloride
- -ve e.p.t.
- Tooth may appear darker

▶ **Previously Endodontically Treated**

- Radiograph indicates root filling present
- -ve to e.c
- -ve to e.p.t.

Apical Diagnoses

▶ **Symptomatic Apical Periodontitis**

- Pain on biting
- TTP
- May see widening of PDL on a radiograph or a peri-apical radiolucency (depends on stage of disease)

▶ **Asymptomatic Apical Periodontitis**

- Clinically, not painful
- Not TTP
- Periapical radiolucency present on radiograph

Apical Diagnoses

▶ **Chronic Apical Abscess**

- Little/no discomfort
- Pus discharge through sinus tract
- On a radiograph, peri-apical radiolucency
- Can use a piece of GP and thread it into sinus tract to locate origin of infection if unclear between 2 adjacent teeth and take radiograph

▶ **Acute Apical Abscess**

- Rapid onset
- Extreme pain
- TTP ++
- Swelling
- If infection spreads, lymphadenopathy, fever and malaise

Toothwear Diagnoses

▶ **Aetiology**

- Attrition
- Abfraction
- Abrasion
- Erosion

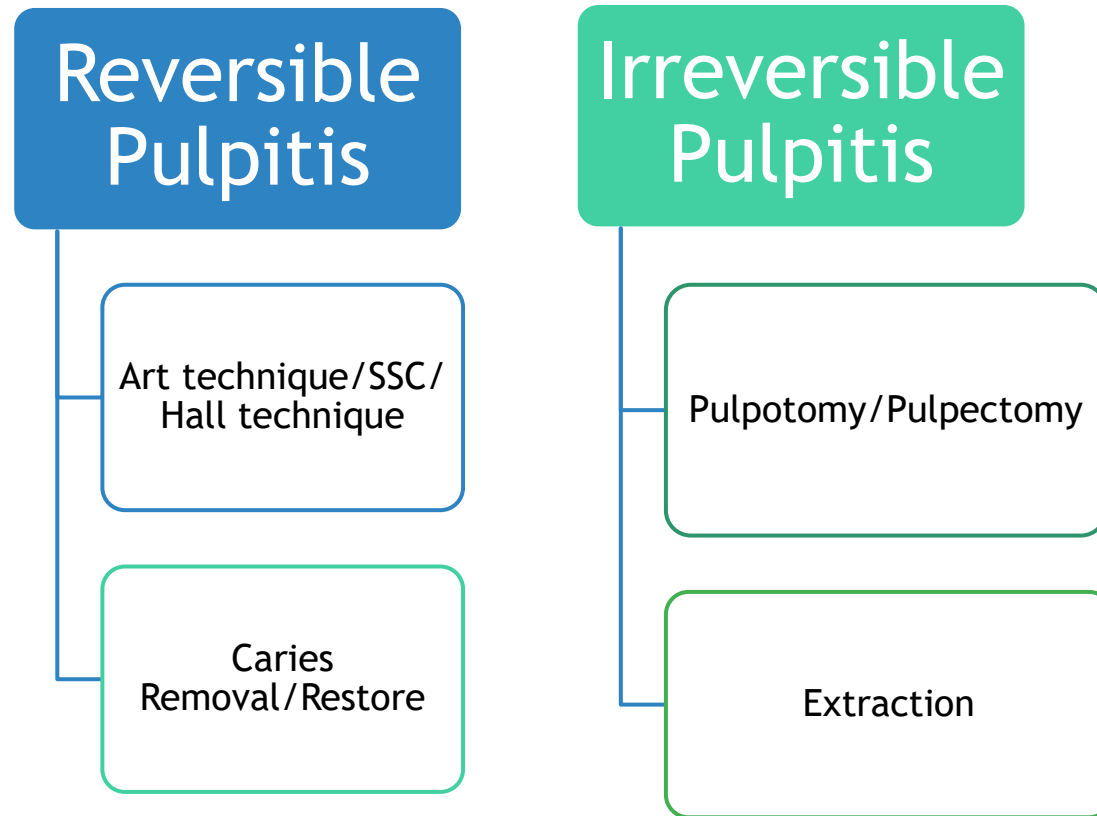
▶ **Pattern**

- Generalised/Localised
- Anterior/Posterior

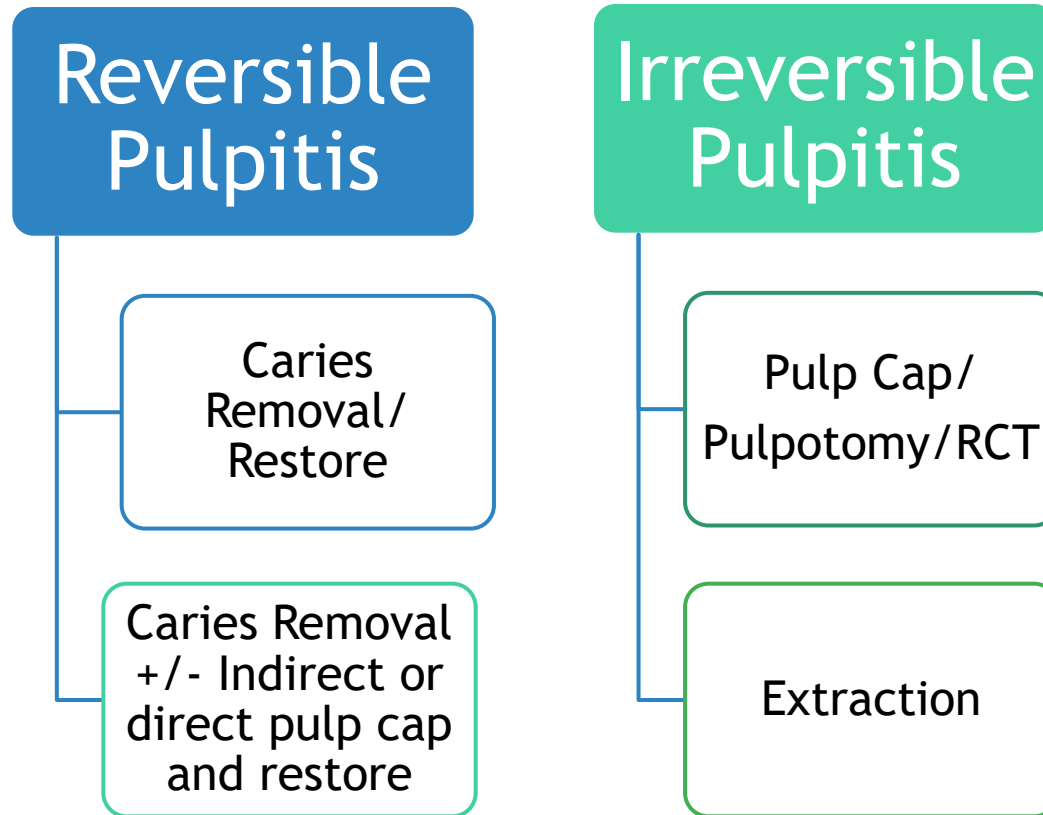
Dentine Hypersensitivity

- Sharp pain
- Normally triggered by a cold stimulus
- Pain disappears when stimulus removed
- Associated with areas of exposed dentine i.e. gingival recession

How to manage Pulpal Diagnoses in Primary teeth



How to manage Pulpal Diagnoses in Permanent Teeth



Options for Restoration

- ▶ RMGI
- ▶ Composite
- ▶ Amalgam **
- ▶ SSC
- ▶ Onlay
- ▶ Inlay
- ▶ Crown

▶ ** Be aware from 1st July 2018 Minamata Treaty reduce use of Amalgam in under 15's

▶ ** The European Parliament has voted to ban dental amalgam from 1 January 2025 ban has been postponed until 2035

How to manage Apical Diagnoses

*****Remove the source of Infection*****

- ▶ Primary teeth = Extraction
- ▶ Permanent teeth :

RCT

Redo RCT

Apicoectomy

Extraction



If presence of swelling will need to give Antibiotics/Analgesics

Post treatment

- ▶ Advice / Post op instructions
- ▶ Analgesics (if needed)
- ▶ Antibiotics (if necessary)
- ▶ Review (if necessary)
- ▶ Prevention message

Toothwear / Dentine Hypersensitivity

- ▶ HX
- ▶ Cease causation
- ▶ Monitor
- ▶ Restore
- ▶ Fluoride gel- Duraphat
- ▶ Flouride mouthwash
- ▶ Sensodyne toothpaste
- ▶ Seal and protect
- ▶ Advice
- ▶ Biteguard

Trauma

25% of all school children experience dental trauma

The observations are that it happens in boys than girls.

Happens in homes rather than in schools

Tooth Injury	Acute Management for Primary Teeth	Acute Management for Permanent Teeth
Enamel Fracture	Check and account for any fragments and reassure Give post-injury advice	As for Primary Teeth; Smooth, Add composite
Enamel- dentine fracture	Check and account for any fragments and reassure. Give post injury advice If symptomatic, dry with cotton wool and seal over the fractured tooth surface with GIC or RMGIC +/- smooth edge with hand-held abrasive disc	Restore with composite +/- lining material or Reattach fragment
Crown fracture involving the pulp	Check and account for any fragments Extract Give post-injury advice	If pin point exposure and seen within 24 hours - Direct Pulp cap. Partial pulpotomy, non setting CAOH, GI & composite. For Mature roots - RCT.

Tooth Injury	Acute Management for Primary Teeth
Crown-root fracture	<p>Taking care not to damage the permanent successor, extract all loose fragments.</p> <p>Leave firm root fragment in situ; or Extract the entire tooth</p> <p>Give post-injury advice</p>
Root fracture	<p>If no, or minimal, occlusal interference from the coronal fragment, leave tooth to reposition spontaneously and observe.</p> <p>If coronal fragment is displaced, excessively mobile and/or interfering with the occlusion, or is a risk of ingestion or inhalation; extract the loose coronal fragment(s) only. The firm apical fragment should be left in-situ to be resorbed.</p> <p>Give post-injury advice</p>

Tooth Injury	Acute Management for Permanent Teeth
<p>Crown - root fracture</p>	<p>Not involving pulp - remove mobile coronal fragment, seal with composite. Immature root - remove coronal fragment, partial pulpotomy, non-setting CAO₂H over exposed pulp, cover with GIC, composite. Mature root - remove coronal fragment and either partial pulpotomy (described above) or RCT or bury root and construct immediate denture.</p>
<p>Root fracture: Apical</p> <p>Mid</p> <p>Cervical</p>	<p>If little or no mobility with no change in position - reassure.</p> <p>If displaced coronal fragment - reposition and splint.</p> <p>Reposition coronal fragment if it is displaced and splint</p> <p>In all cases warn of prognosis and need for RCT or Extraction</p>

Tooth Injury	Acute Management for Primary Teeth	Acute Management for Permanent Teeth
Alveolar fracture	<p>Under local anaesthesia reposition any displaced segment which is mobile and/or causing occlusal interference.</p> <p>Stabilise to adjacent uninjured teeth with flexible splint.</p> <p>Give post-injury advice</p>	<p>Similar to Primary Teeth</p>
<p>Concussion (occurs when PDL that holds tooth in place is damaged and leads to discolouration)</p> <p>Subluxation (mobile tooth that has not been displaced- bleeding around gum line and sensitive to touch)</p>	<p>Observation</p> <p>Give post-injury advice</p>	<p>Similar to Primary Teeth</p> <p>Warn re: Loss of vitality</p> <p>RCT/Extraction</p>

Tooth Injury	Acute Management for Primary Teeth	Acute Management for Permanent Teeth
Extrusion (displacement of tooth out of its socket)	If no, or minimal, occlusal interference leave tooth to reposition spontaneously - observe If the tooth is excessively mobile or extruded >3mm then extract - especially if there is a risk of ingestion or inhalation. Give post-injury advice	Reposition displaced tooth and splint Watch for pulp necrosis

Tooth injury	Acute Management for Primary Teeth
Lateral luxation (displacement of tooth in a direction other than apically)	If no or minimal occlusal interference leave tooth to reposition spontaneously - observation If tooth is severely displacement then extract Give post-injury advice
Intrusion (Apical displacement of tooth into alveolar bone)	The tooth is allowed to spontaneously reposition irrespective of the direction of displacement - observation Give post-injury advice
Avulsion (complete displacement of tooth out of socket)	Avulsed primary teeth should not be replanted. Check and account for tooth and reassurance. Give post-injury advice

Tooth injury	Acute Management for Permanent Teeth
Lateral luxation	Reposition displaced tooth and splint
Intrusion (Immature) (Mature tooth)	Allow re-eruption without intervention - Passive re-eruption Less than 7mm - allow re-eruption without intervention - Passive reeruption Greater than 7mm - surgically reposition and splint/rct
Avulsion	Re Implant, splint, monitor, +/- RCT

International Association of Dental Traumatology

- ▶ Dental Trauma Guide



- ▶ IADT ToothSOS App





When to Refer?

- ▶ Need for specialist treatment
- ▶ If you feel out of your depth
- ▶ Patient non co-operative
- ▶ Practice unsuitable for patient
- ▶ Life threatening condition
- ▶ Need for second opinion

Where to Refer??

- ▶ High Street Oral Surgery
- ▶ CDS
- ▶ Referral to Hospital Dental Services
- ▶ [Referral Guidelines for Hospital Dental Services - Business Services Organisation \(BSO\) Website](#)

The screenshot displays the HSC Business Services Organisation website. At the top left is the HSC logo and the text 'Business Services Organisation'. To the right is a search bar with the placeholder text 'Enter your search here'. Below this is a dark blue navigation bar with links: Home | BSO News | Directorates | HSC Values | HSCNI Statistics | Jobs | About the BSO | Contact us. A breadcrumb trail below the navigation bar reads: Home > Directorates > Directorate of Operations > Family Practitioner Services > FPS Dental Services > Contractor Information > Referral Guidelines for Hospital Dental Services. The main content area features a dark blue header for 'Referral Guidelines for Hospital Dental Services'. Underneath, there is a 'Contact Information' section with two links: 'Click [HERE](#) for details on the Trusts Hospital OMFS Referrals and Contacts (Ver. 4.0)' and 'Click [HERE](#) for details on the Trusts Hospital Orthodontic Referrals and Contacts (Ver. 2.0)'. At the bottom of this section, it says 'Updated: 5th November 2025'. To the right of the main content is a sidebar titled 'Also in this Section' with three links: 'Adverse Incident Reporting', 'Dental Prescribing Guidance', and 'BSO Dental Portal'.



It's Quiz Time!



▶ Number 1



A

Number 2



Number 3



Number 4



Number 5



Number 6



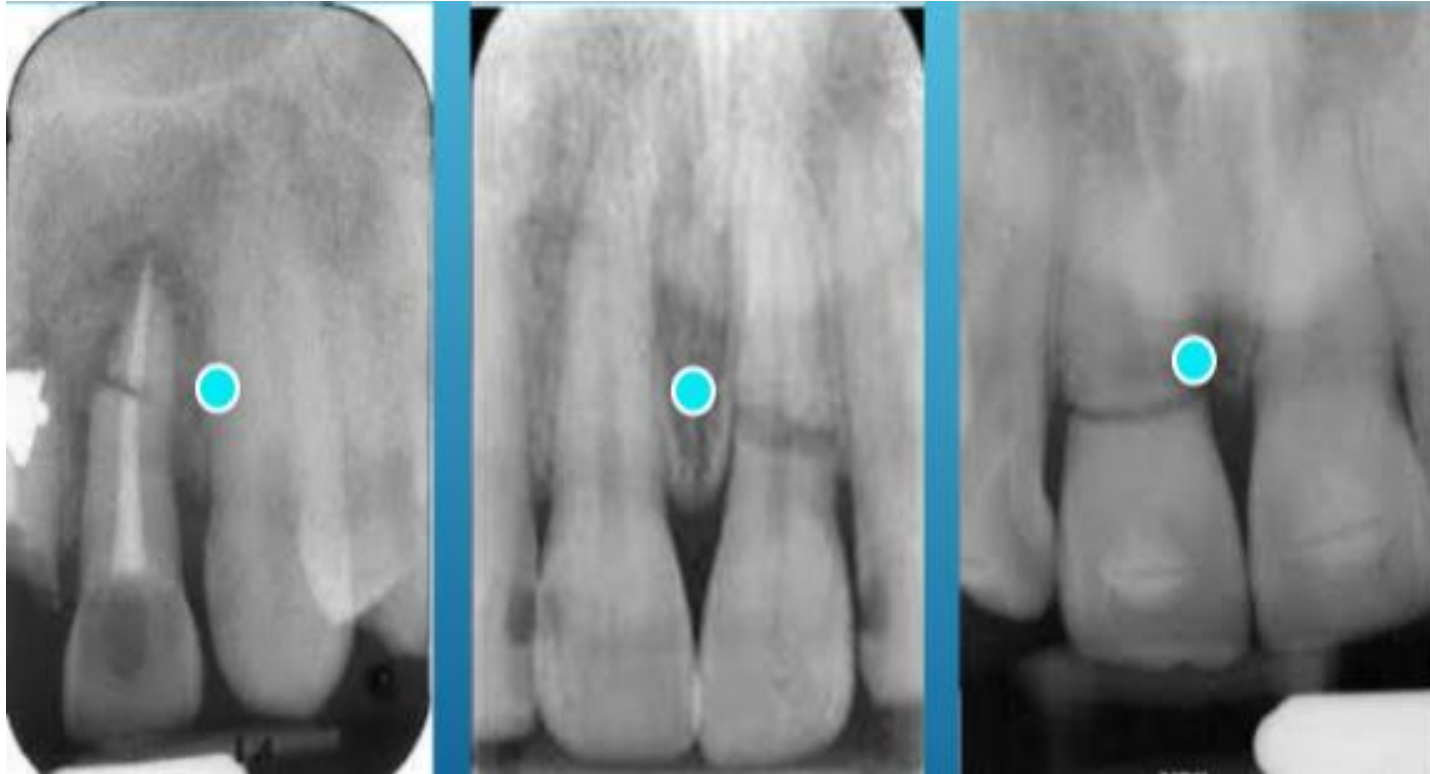
Number 7



Number 8

Number 9





Number

10A

10B

10C

Quiz Answers

- ▶ Number 1 : Lateral Luxation
- ▶ Number 2 : Avulsion with an Extrusion
- ▶ Number 3 : Intrusion
- ▶ Number 4 : Extrusion
- ▶ Number 5 : Enamel Fracture
- ▶ Number 6 : Concussion (few months later and abscess has developed)
- ▶ Number 7 : Enamel/Dentine Fracture with Pulp involvement
- ▶ Number 8: Subluxation
- ▶ Number 9: Avulsion of Permanent tooth
- ▶ Number 10A: Apical Root #, 10B: Mid Root #, 10C: Cervical Root #

Important to remember to
follow up and review
trauma cases

Ensure good record
keeping

Be aware of medio- legal

Recognising the signs and clinical presentations of child in pain

- ▶ Complaining of pain
- ▶ Pain/sensitivity to hot +cold
- ▶ Kept awake at night
- ▶ Crying
- ▶ Screaming
- ▶ Not wanting to brush teeth
- ▶ Shrugging away with brushing
- ▶ Parent notices wincing e.g. when eating/drinking
- ▶ Holding their face
- ▶ Off their food
- ▶ Ear ache
- ▶ Pain relief not helping



Presentation in surgery

- ▶ Not wanting to come into surgery
- ▶ Hiding behind parent/guardian
- ▶ Reluctant to get up on chair
- ▶ Wont allow chair to go back
- ▶ Will not open their mouth
- ▶ Crying
- ▶ Shaking/trembling
- ▶ Holding on to hand of adult that brought them
- ▶ Runs into the surgery/ sits on chair and opens wide



Prior to Exam

- ▶ Get down to child level
- ▶ Reassure child
- ▶ Speak to patient not parent
- ▶ Explain everything to them in language they understand
- ▶ Try to build rapport
- ▶ Ask them to explain what is wrong with them
- ▶ Let them point to the area
- ▶ Advise them you are trying to help them
- ▶ Allow patient to sit on parent's knee on dental chair
- ▶ Do exam on ordinary chair or with patient standing up



Tips to manage clinical exam

Child will dictate this

Parent may dictate

Important to explain what you are going to do

Tell show do

Can sit child upright for exam

Let child or nurse hold large mirror so they can see what is going on

Let them have a go pushing buttons

Use 3 in 1 on child's hand/ then tickle there teeth with it

Child holding cotton wool roll

Use of props

Sharp probe call it pointer/ touch glove so they can see not sore

Brush teeth to facilitate doing exam

How wide can you open? What animal are you? Tongue exercises



- ▶ Clinical and radiographic exam are good indicators of the level of treatment patient will allow.





Options for Treatment

- ▶ Advice
- ▶ No Anaesthetic
- ▶ Topical Anaesthetic
- ▶ Local Anaesthetic
- ▶ Relative Analgesic
- ▶ *IV sedation*
- ▶ General Anaesthetic

Topical Anaesthetic

- ▶ Judge the child - whether to let them taste on tip of tongue (generally I don't)
- ▶ Let them hold cotton wool/ Cotton bud
- ▶ Let them be in control
- ▶ “Bubblegum jelly”
- ▶ Leave for sufficient time to work

Local Anaesthetic

- ▶ Do not show child the Needle!!!
- ▶ Magic wand
- ▶ Don't use the words inject or needle
- ▶ Use the word “spray” as an alternative
- ▶ Don't lie to child if they ask you - but don't go out of your way to tell them!!

- ▶ Beware of parents input

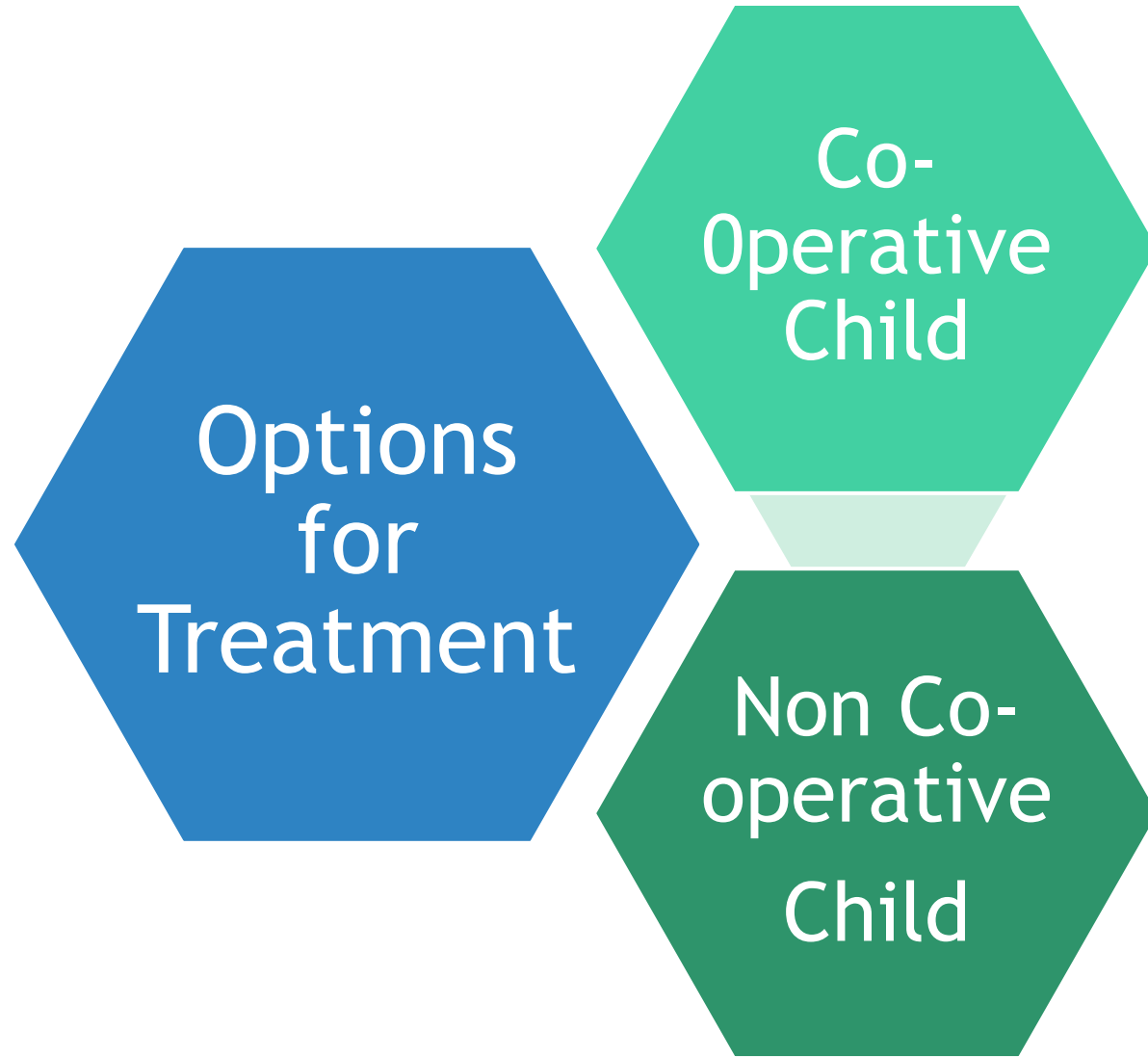
Extractions of primary teeth under LA can be challenging at the emergency appointment especially with a distressed or pre-cooperative child. In some situations, clinical teams may choose to delay the extraction until a follow-up visit to minimise the potential for the development of post-traumatic stress and/or dental anxiety

Regional Anaesthetic

- ▶ Patient is awake
- ▶ Need to have good level of co-op for this
- ▶ Isn't a miracle worker - make parents aware of this
- ▶ Child needs to be able to breath through nose
- ▶ Ensure have consent from parent prior to doing RA
- ▶ Still need LA with it
- ▶ Great when it works - prevents GA

IV sedation

- ▶ Need extra qualification
- ▶ Need to refer for treatment
- ▶ Not suitable/safe for young children
- ▶ Usually over 16
- ▶ Prevents GA



Co-operative patient v non co-operative patient

- ▶ Co-operative patient will sit and get treatment completed, it might be a struggle but they will get it done
- ▶ Non co-operative patient will not allow treatment

What to do with the non co-operative patient??

- ▶ Try to get exam and radiographs
- ▶ If patient won't allow LA then....

Options if no success

- ▶ If at first don't succeed - bring back / try again
- ▶ Allow another GDP in practice to treat
- ▶ Use RA
- ▶ No RA in practice - Refer to CDS
- ▶ No co-operation after RA - Refer to CDS for GA

Statement of Purpose

The Community Dental Service (CDS) serves the community by providing direct patient care and preventive programmes to people who, because of their special care needs, are unable to access appropriate dental services elsewhere. These services are provided in both Community and Hospital settings. We will be a model of best practice in providing oral healthcare which is high quality, evidence-based and timely.

Values

In order to ensure that we achieve our statement of purpose we will:

- Ensure that we have the necessary **skills and competencies** to deliver a quality service
- Ensure that our delivery of oral healthcare service enshrines **best practice and the available evidence-base** and is open to innovative approaches to working
- Ensure that we have robust **accountability arrangements**
- **Manage our resources**, including our time, as efficiently and effectively as possible
- Demonstrate a **commitment** for fairness, equality and respect for each other and our patients
- Promote **team-working** and working in partnership with others both inside and outside the health sector

1. Scope of Service

(a) Providing oral care, including GA/Sedation, for people with Special Care Needs:

- a learning disability
- a compromising medical condition
- a mental illness
- physically disabled
- housebound/ institutional resident
- patients with significant anxiety or behavioural difficulties who cannot be treated in a general dental practice
- children identified as high risk by demographic or health indicators who are not suitable for general dental practice.

(b) Evidence based oral health improvement programmes

- evidence-based Caries Reduction Programme (EBCRP); for the following groups: young children, the elderly, special care needs
- all Oral health education and oral health improvement programmes should be agreed with the Northern Ireland Oral Health Improvement Group (NIOHIG)

(c) Needs Assessment (Epidemiology)

- screening groups identified as part of the local Service Agreement (SA)[†]
- undertaking national and local surveys as directed by the HSCB/DHSSPS

(d) Research

undertaking/facilitating agreed research

2. Governance & Accountability

(a) Production of annual business plan in line with the SA[†]

- defining long and short-term objectives
- setting targets
- identifying milestones
- producing activity returns and management information

(b) Governance

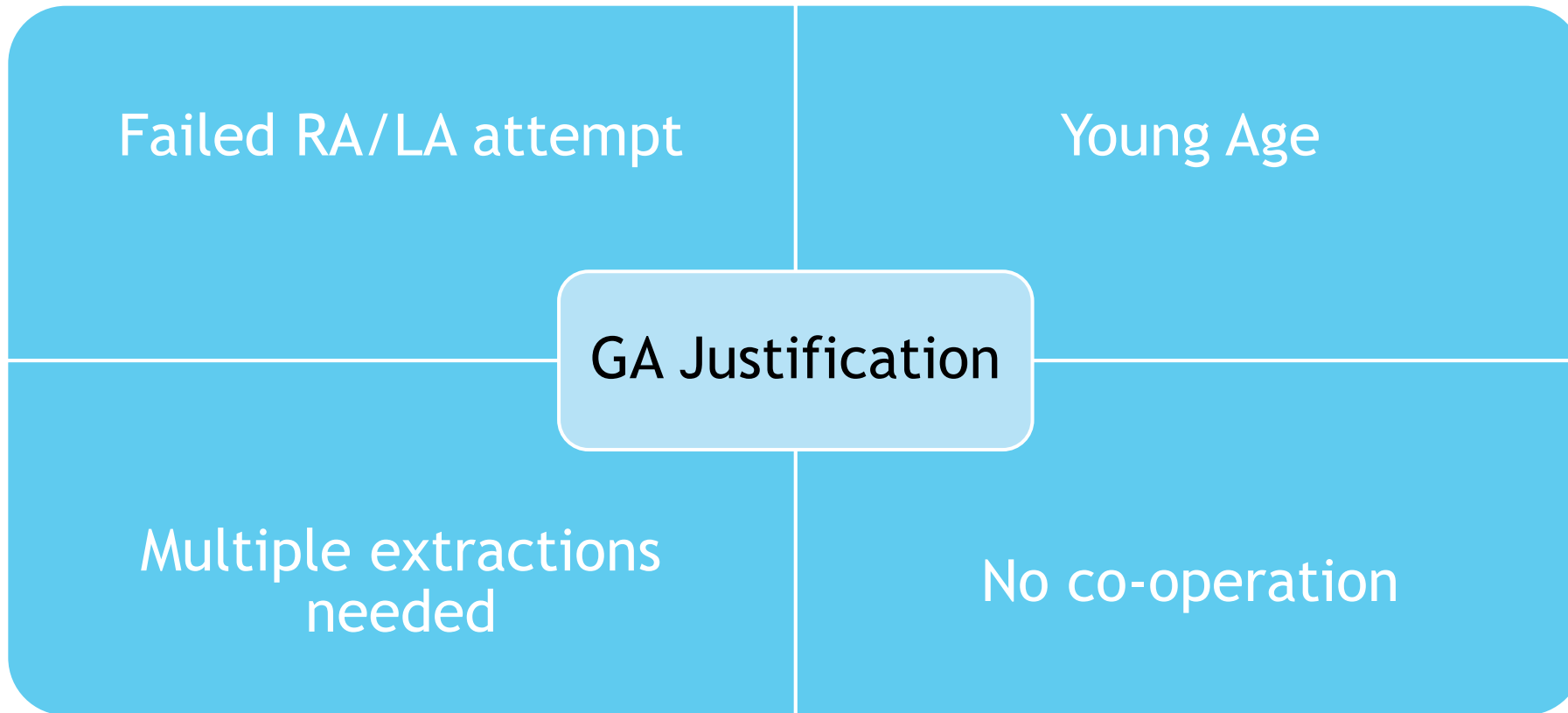
- develop a sound system of internal control that supports achievement of targets and objectives
- review the adequacy of clinical governance, risk management and standards compliance.
- participate in an annual accountability review with the HSCB to review performance against the SLA.
- take part in uni- and multi-disciplinary audit/peer review as required

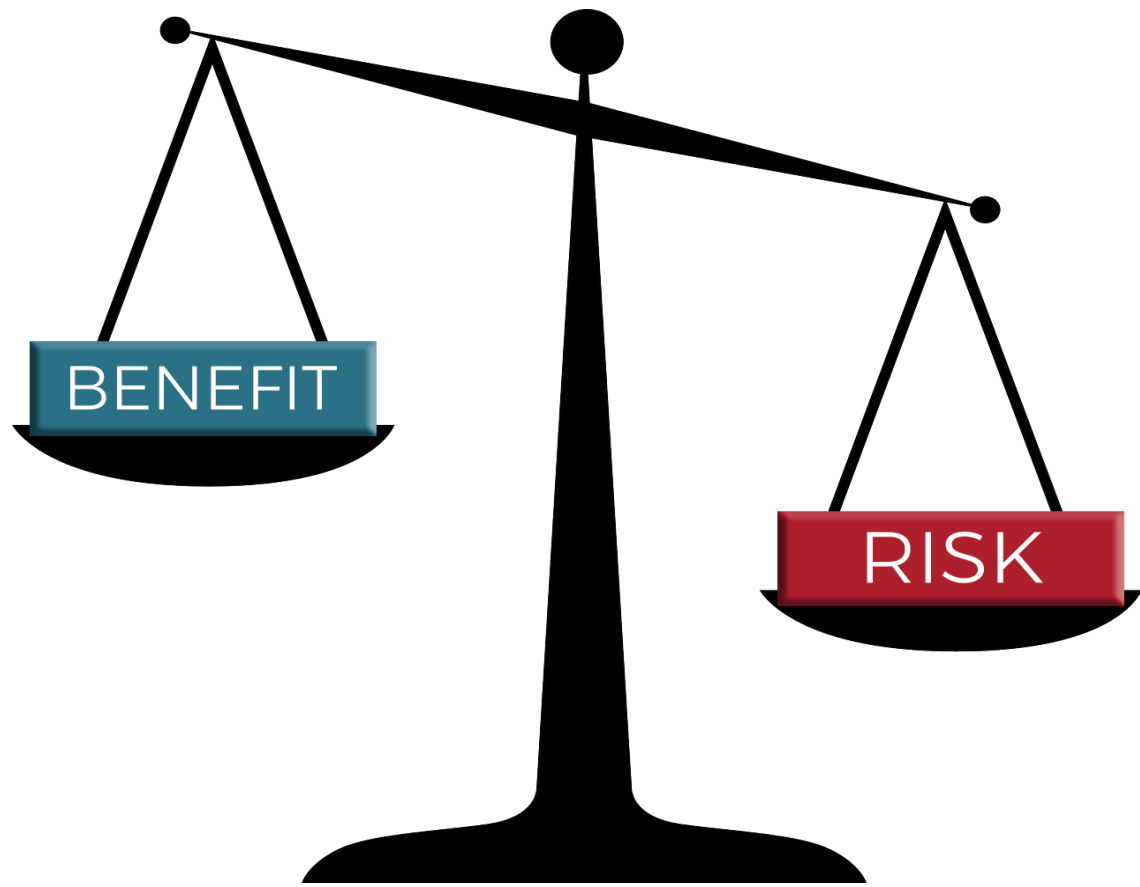
[†] The SA is an agreement between the HSCB and HSC Trust

Referring to the CDS

- ▶ Use the patient's home postcode not your practice postcode
- ▶ Give as much information as possible
- ▶ Justify your referral
- ▶ Make parent aware of waiting times
- ▶ Referral forms obtained from BSO website or phone local CDS surgery

General Anaesthetic





▶ [\(25\) Six-year-old Mario is having his teeth pulled | Jamie's Sugar Rush - YouTube](#)

Percentage of Registered Children Who Received At Least One Of The Following Treatments

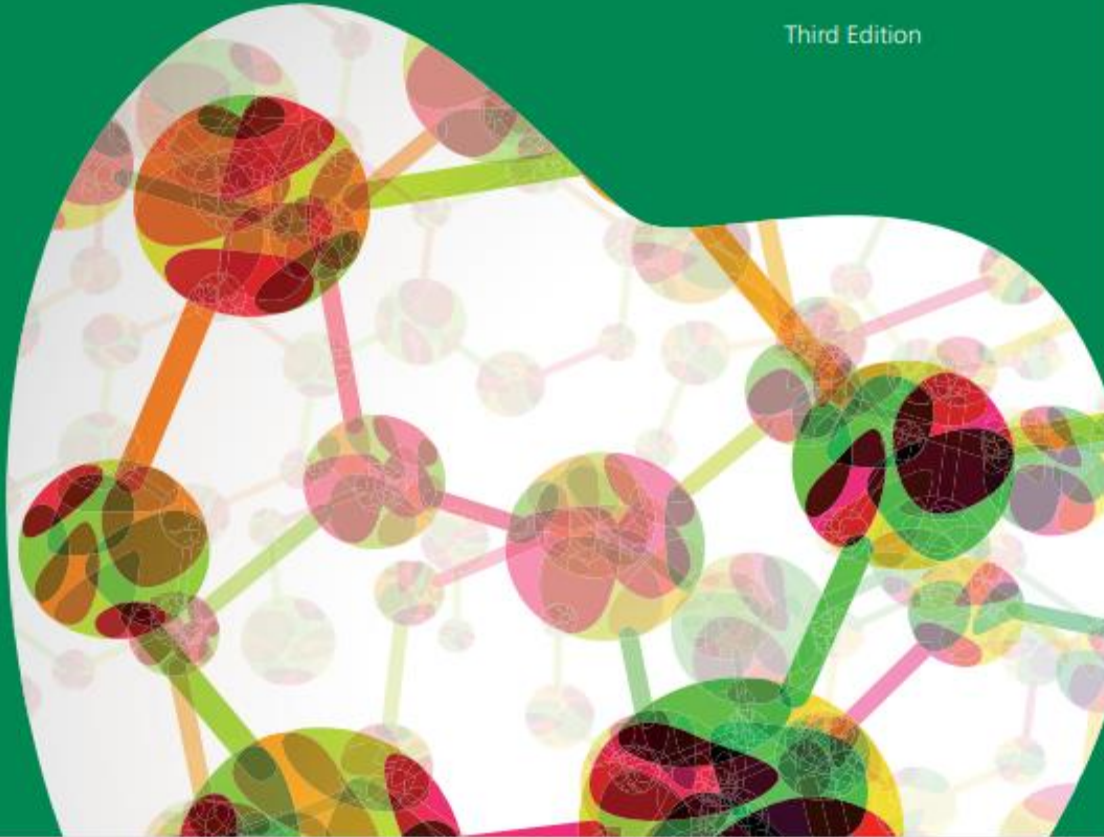
Financial Year	Filling (%)	Extraction (%)	X-Ray (%)	Ortho (%)
2015/16	23.8	5.8	6.5	9.6
2016/17	23.3	5.7	5.6	8.6
2017/18	22.1	5.4	5.3	7.8
2018/19	22.1	5.2	5.2	7.5
2019/20	21.0	5.2	5.1	7.4
2020/21	6.6	2.8	2.4	5.4
2021/22	12.0	4.2	3.6	6.5
2022/23	16.6	4.8	4.3	6.6
2023/24	16.1	4.9	4.6	6.6
2024/25	17.7	5.3	5.7	8.0

A collection of medical supplies including capsules, pills, a syringe, and a vial, with the word 'Antibiotics' written in the center. The scene is set on a white surface with a blue gradient background on the right. The word 'Antibiotics' is written in a black, cursive font. Surrounding the text are various pharmaceutical items: three light blue capsules at the top, a glass vial with blue liquid on the right, a syringe with a blue plunger and a needle pointing left across the text, and several red and yellow capsules and a red pill at the bottom. A silver and blue syringe is partially visible in the top left corner.

Antibiotics

Drug Prescribing For Dentistry
Dental Clinical Guidance

Third Edition



Amoxicillin

Amoxicillin Capsules, 500 mg

Send: 15 capsules

Label: 1 capsule three times daily

For children:

Amoxicillin Capsules, 250 mg, or Oral Suspension*, 125 mg/5 ml or 250 mg/5 ml

6-11 months	125mg three times daily
1-4 years	250 mg three times daily
5-11 years	500 mg three times daily
12-17 years	500 mg three times daily

NB: The dose of amoxicillin should be doubled in severe infection in adults and children aged 12-17 years. In severe infection in children aged 6 months to 11 years, the dose of amoxicillin should be increased up to 30 mg/kg (max 1 g) three times daily.

Amoxicillin, like other penicillins, can result in hypersensitivity reactions, including rashes and anaphylaxis, and can cause diarrhoea. Do not prescribe amoxicillin to patients with a history of anaphylaxis, urticaria or rash immediately after penicillin administration as these individuals are at risk of immediate hypersensitivity.

*Sugar-free preparation is available.

- ▶ Amoxicillin as oral suspension
- ▶ Eg. 125mg/5ml amoxicillin oral suspension (sugar free)
250mg/5ml Amoxicillin oral suspension(sugar free)

PHENOXYMETHYLPENICILLIN (Penicillin V)

Phenoxymethylpenicillin Tablets, 250 mg

Send: 40 tablets

Label: 2 tablets four times daily

For children:

Phenoxymethylpenicillin Tablets, 250 mg, or Oral Solution*, 125 mg/5 ml or 250 mg/5 ml

6-11 months	62.5 mg four times daily
1-5 years	125 mg four times daily
6-11 years	250 mg four times daily
12-17 years	500 mg four times daily

NB: For severe infection in adults, the dose of phenoxymethylpenicillin should be doubled. For severe infection in children up to 11 years, increase dose up to 12.5 mg/kg four times daily. For severe infection in children aged 12-17 years increase dose up to 1 g four times daily.

Phenoxymethylpenicillin, like other penicillins, can result in hypersensitivity reactions, including rashes and anaphylaxis, and can cause diarrhoea. Do not prescribe phenoxymethylpenicillin to patients with a history of anaphylaxis, urticaria or rash immediately after penicillin administration as these individuals are at risk of immediate hypersensitivity.

*Sugar-free preparation is available

Metronidazole

Metronidazole Tablets, 200 mg

Send: 15 tablets

Label: 1 tablet three times daily

For children:

Metronidazole[†] Tablets, 200 mg, or Oral Suspension, 200 mg/5 ml

1-2 years	50 mg three times daily
3-6 years	100 mg twice daily
7-9 years	100 mg three times daily
10-17 years	200 mg three times daily

NB: For severe infection, the dose of metronidazole should be doubled in adults and children aged 12-17 years.
For severe infection in children up to 11 years, increase dose up to 7.5 mg/kg (max. 400 mg) three times daily.
Advise patient to avoid alcohol (metronidazole has a disulfiram-like reaction with alcohol).
Do not prescribe metronidazole for patients taking warfarin.
[†]Metronidazole is not licensed for use in children under 1 year (see Section 1.1.5).



ANALGESIC

Paracetamol

Paracetamol Tablets, 500 mg

Send: 40 tablets

Label: 2 tablets four times daily

For children:

Paracetamol Tablets or Soluble Tablets, 500 mg, or Oral Suspension*, 120 mg/5 ml or 250 mg/5 ml

6 months-1 year	120 mg four times daily (max. 4 doses in 24 hours)
2-3 years	180 mg four times daily (max. 4 doses in 24 hours)
4-5 years	240 mg four times daily (max. 4 doses in 24 hours)
6-7 years	240-250 mg four times daily (max. 4 doses in 24 hours)
8-9 years	360-375 mg four times daily (max. 4 doses in 24 hours)
10-11 years	480-500 mg four times daily (max. 4 doses in 24 hours)
12-15 years	480-750 mg four times daily (max. 4 doses in 24 hours)
16-17 years	500 mg-1 g four times daily (max. 4 doses in 24 hours)

NB: Advise patients that paracetamol can be taken at 4-hourly intervals but not to exceed the recommended daily dose (maximum of 4 g for adults). Overdose with paracetamol is dangerous because it can cause hepatic damage that is sometimes not apparent for 4-6 days and can be fatal. Note that a patient who ingests a therapeutic excess (defined as more than the recommended daily dose [8 x 500 mg tablets for adults] **AND** more than or equal to 75 mg/kg in any 24 hour period) should be referred for assessment in an emergency department (for more information see page 49).

*Sugar-free preparation is available.

Ibuprofen

Ibuprofen Tablets, 400 mg

Send: 20 tablets

Label: 1 tablet four times daily,
preferably after food

For children:

Ibuprofen Oral Suspension*, 100 mg/ 5 ml or Ibuprofen Tablets, 200 mg

6-11 months	50 mg four times daily, preferably after food
1-3 years	100 mg three times daily, preferably after food
4-6 years	150 mg three times daily, preferably after food
7-9 years	200 mg three times daily, preferably after food
10-11 years	300 mg three times daily, preferably after food
12-17 years	300-400 mg four times daily, preferably after food

NB: In adults, the dose of ibuprofen can be increased, if necessary, to a maximum of 2.4 g daily.

Avoid use in those with a hypersensitivity to aspirin or any other NSAID, including those in whom attacks of asthma, angioedema, urticaria or rhinitis have been precipitated by aspirin or any other NSAID. Do not prescribe for patients taking a low dose of aspirin daily. Avoid use in pregnant patients and avoid in those with previous or active peptic ulcer disease, unless a proton pump inhibitor is co-prescribed (see page 54). Use with caution in the elderly, patients with allergic disorders, nursing mothers, those taking oral anticoagulants such as warfarin, those with coagulation defects, those with an inherited bleeding disorder, and those with renal, cardiac or hepatic impairment. Restrict ibuprofen use to 5 days or less in those patients taking antihypertensive drugs. See Appendix 4 for more information on potential drug interactions.

*Sugar-free preparation is available.

- ▶ Aspirin don't use on under 16's as could cause Reye's syndrome
- ▶ Diclofenac not recommended for use in children
- ▶ Diazepam : due to its unpredictable effect in children it is not recommended to prescribe.

Anxiety Management

- ▶ An oral dose of a benzodiazepine may be used as premedication to aid anxiety management before dental treatment. However, note that benzodiazepines are addictive and susceptible to abuse and therefore only the minimum number of tablets required should be prescribed. Advise the patient that they will require an escort and that they should not drive.
- ▶ For children: Not recommended because it has an unpredictable effect in children

Other factors involved in treating children

- ▶ Medical History
- ▶ Special Needs
- ▶ Social History
- ▶ Social Worker
- ▶ Consent
- ▶ Clinical holding
- ▶ NAI - non accidental injury
- ▶ Oral Health/Prevention message

In Summary

- ▶ Treating children can be difficult
- ▶ Treating children in pain can be more difficult
- ▶ Children are unpredictable
- ▶ Your job to help
- ▶ Try your best
- ▶ Be aware of your limitations
- ▶ Refer if necessary
- ▶ Justify your actions
- ▶ Review
- ▶ Keep parent/guardian informed

Cases for Group Discussion



Case 1

Emergency appointment for 2 year old girl called Emma trips and falls at home attends with mum having fractured her central incisors.

- ▶ How would you manage and what do you need to consider?

Case 1

- ▶ ? Previous dental experience
- ▶ Exam/Radiographs
- ▶ Need to ascertain extent injury and treat accordingly
- ▶ Consider airway risk - if so extract - compliance
- ▶ Clinical holding
- ▶ ? NAI
- ▶ Head injury/ Soft tissue injuries/fragment in lips
- ▶ Review/Monitor

Case 2

- ▶ John is a 5 year old boy first time at dentist and is complaining of pain in lower right E. Granny has brought him to the appointment, he lives with her and she said that he has been up crying in pain this last three nights and he has large swelling on the right side.
- ▶ How would you manage? What do you need to consider?

Case 2

- ▶ Need to help with pain
- ▶ Co- op for extraction
- ▶ Can granny consent?
- ▶ Any other teeth of poor prognosis
- ▶ ? Need to refer for GA
- ▶ Antibiotics
- ▶ Review
- ▶ ? Airway risk
- ▶ ? Refer to paed's or send to ED

Case 3

- ▶ 7 year old Amy attends with parent. She is a regular attender with sound dentition but she is complaining of sharp pain in upper left quadrant.
- ▶ How would you manage? what do you need to consider?

Case 3

- ▶ Get more history. Any associations with the pain?
- ▶ Are teeth all sound?
- ▶ Any sensitivity to 3 in 1
- ▶ Bitewings show anything
- ▶ Any mobile or fractured teeth?
- ▶ TMJ problems
- ▶ Saliva duct blockage
- ▶ NB check soft tissues

Case 4

- ▶ 15 year old boy Daniel attends with Dad complaining of pain when he is drinking his luxoczade sport. He has a large carious cavity in his central incisor.
- ▶ How would you manage this and what do you need to consider?

Case 4

- ▶ Type of pain
- ▶ Is tooth vital?
- ▶ Co -operation for treatment
- ▶ Need for RCT
- ▶ RA difficult with anterior tooth
- ▶ Is tooth restorable
- ▶ Options if not restorable
- ▶ Oral health message

Case 5

- ▶ 11 year old girl with grossly carious lower 6's, kept awake at night with pain coming from the LR6.
- ▶ How would you manage? What would you need to consider?

Case 5

- ▶ Grossly carious likely extraction
- ▶ Ortho opinion
- ▶ ? Co- operation
- ▶ ?GA
- ▶ Consent
- ▶ Get patient out of pain whilst awaiting treatment
- ▶ 1st stage RCT awaiting ext

Case 6

- ▶ 14 year old girl has come to the appointment on her own. She is complaining of pain from the UL5. The patient says she wants the tooth out today.
- ▶ How would you manage this? What would you do you need to consider?

Case 6

- ▶ Patient here on her own
- ▶ Contact parent
- ▶ Patient's age
- ▶ Act in best interest
- ▶ Get patient out of pain
- ▶ Hold off on extraction
- ▶ Consent
- ▶ ?Ortho opinion



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[British Society of Paediatric Dentistry \(BSPD\) > Professionals > Resources > BSPD Guidelines](#)

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That's all Folks!