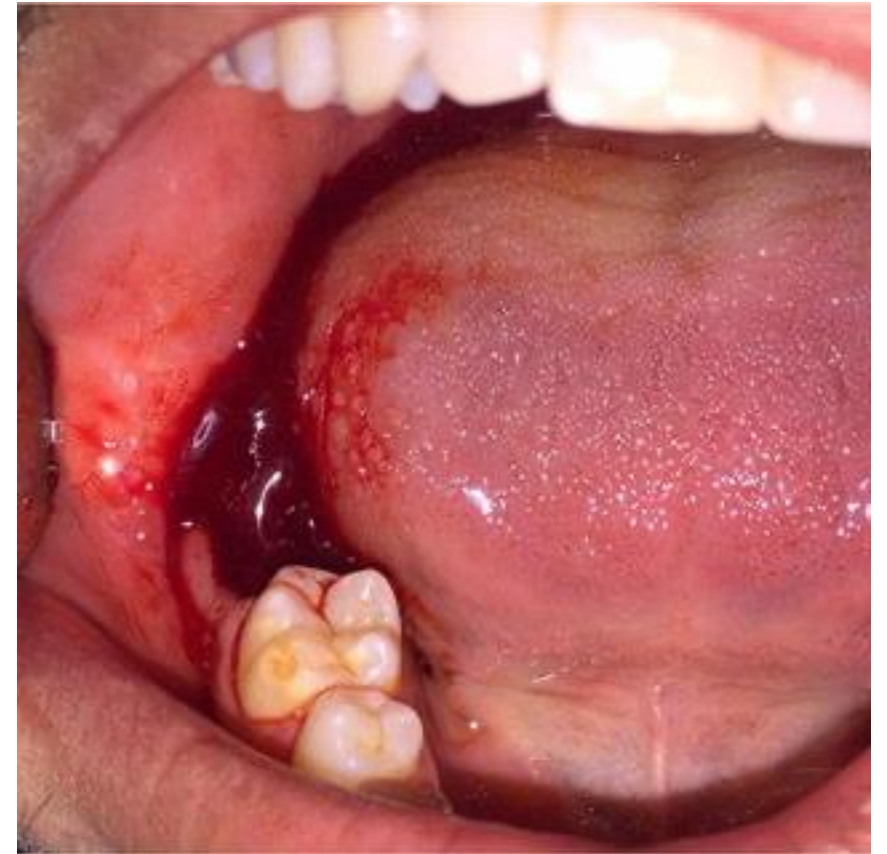


MANAGEMENT OF HAEMORRHAGE

Oral & Maxillofacial Surgery · Dental Core Trainee Teaching

Bleeding sockets are a common problem YOU will be called to see.





News

Dentist Suspended Due To Patient Bleeding To Death After He Extracted Ten Of Her Teeth

October 23, 2019

by The Telegraph

A dentist has been banned from practising for a year after one of his patients bled to death only hours after he [extracted ten of her teeth](#).

Tushar Patel, who worked at Confidential Clinics in Purley, Surrey, treated a woman [suffering from advanced gum disease](#), known as Patient A, in the summer of 2017.

She had been taking a blood-thinning medicine called Warfarin for a rare blood condition that causes clotting.

To view the full story, [please click here](#).

[See more of the latest dentistry news here!](#)

The call that arrives at 2 a.m.

"Patient had LR8 removed yesterday. Re-presented this evening with bleeding. GDP has tried pressure and a pack. Still oozing. Can you see them?"

— Typical phone referral from GDP or A&E

Simple extraction

Even routine lower molars can produce significant bleeding — especially with inflamed gingivae or pericoronitis.

Looks worse than it is

Rinse the blood away first. Most “torrential” sockets settle once the source is identified and packed.

Rare but real

AV malformations and coagulopathies exist. Have a low threshold to escalate if local measures fail.

By the end of this session

01

Take the call

Give safe initial advice to GDP / A&E

02

Assess

Focused history + systematic exam

03

Treat the socket

LA → clear → pack → suture → pressure

04

Suture well

Figure-of-8 and horizontal mattress

05

Escalate

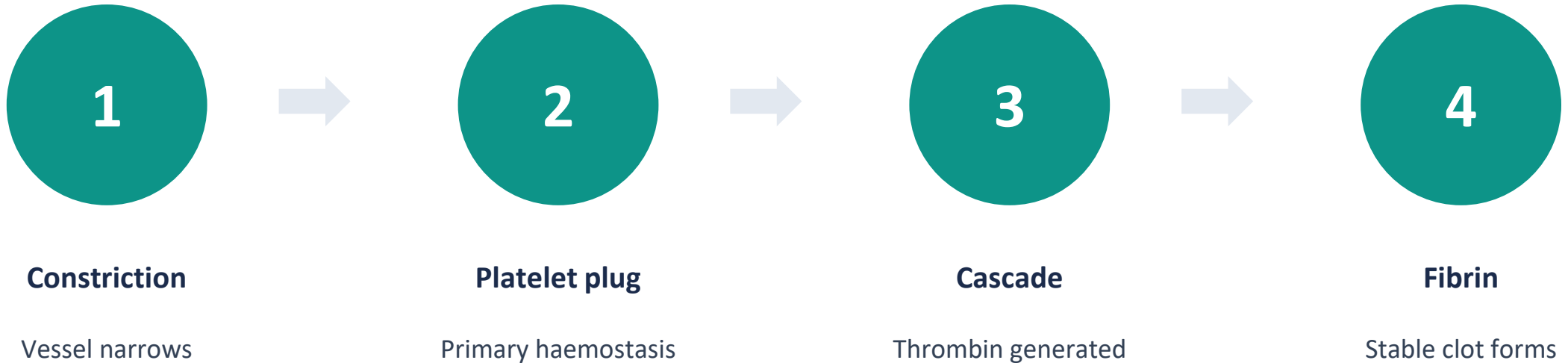
When to call seniors / haematology / theatre

06

Anticoagulants

Warfarin + current DOAC reversal

Four steps to a stable clot



Drugs, disease or local factors can disrupt any of these steps.

What do you need to know?

FROM THE REFERRER

- Seen face-to-face?
- Reason for extraction
- Difficulty / bone removal
- Measures already tried
- Time of onset

MEDICAL

- Anticoagulants / antiplatelets
- Bleeding disorders
- Liver disease / alcohol
- Recent chemo / marrow
- Previous post-op bleed

CURRENT STATUS

- Estimated blood loss
- Systemic signs
- Able to cooperate?
- Social support
- Observations if in ED

Advice to the GDP before transfer

Not unreasonable to insist these are done first

1

LA

Infiltration or block so the patient can tolerate packing and suturing

2

Pressure

Firm gauze bite for 10–15 minutes

3

Haemostatic agents

Surgicel, sponge, gelatin foam or TXA-soaked gauze

4

Suture

Horizontal mattress or figure-of-8 to close and retain pack

Who needs to come in?

Failed local control

GDP has already done LA + pack + suture + pressure

Systemic signs

Tachycardia, hypotension, pallor, breathlessness

High-risk patient

Frail, dual therapy, known coagulopathy

Multiple sites / trauma

Several sockets or concurrent soft-tissue injury

Parallel processes on arrival

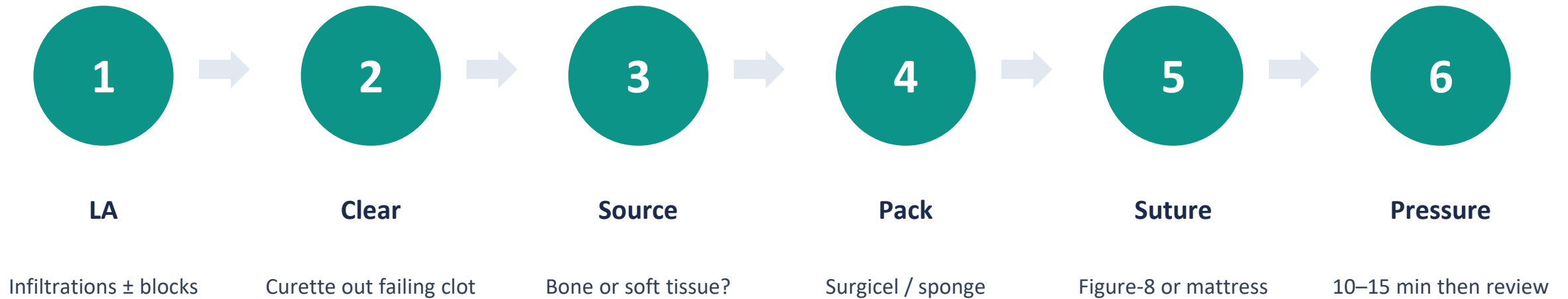
DO THIS FIRST

1. Pressure with TXA / adrenaline gauze while you talk
2. Look for pallor, cyanosis, tachypnoea
3. Confirm times, volume, nature of bleeding
4. Get LA in early — bloods will not change initial management

THEN EXAMINE

- Arterial spurting or venous ooze?
- Clot present / absent / exuberant?
- Swelling intra- or extra-oral?
- Sutures or pack already in?
- Loose mucoperiosteal flap?
- Rinse — find the exact source

The reliable sequence



Real-world tip

*"Usually looks worse than it is — rinse away the blood and identify the source.
Get on and try to stop the bleeding while bloods are processing."*

Figure-of-8 (cruciate) suture

TECHNIQUE STEPS

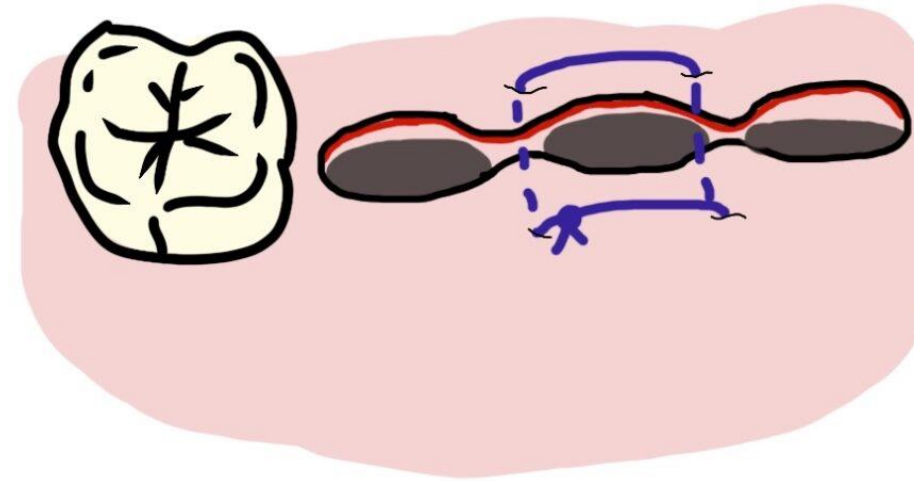
- 1 Enter buccal papilla ~3 mm from edge
- 2 Pass diagonally across socket to lingual
- 3 Exit, reverse needle direction
- 4 Enter opposite buccal papilla → lingual
- 5 Cross back (forms the characteristic X)
- 6 Tie over the pack — retains haemostatic agent



Horizontal mattress suture

TECHNIQUE STEPS

- 1 Enter ~5–6 mm from edge on one side
- 2 Pass across the socket to opposite side
- 3 Exit, then re-enter 3–5 mm along the edge
- 4 Pass back under the tissue
- 5 Exit opposite the original entry point
- 6 Tie — creates two parallel surface strands



Investigations — useful but do not delay local control

Observations

BP, HR, RR, SpO₂
Trend is more useful than a single reading

Bloods

FBC (Hb + platelets)
Coag screen / INR
LFTs

Imaging

OPG +/- PA mandible if residual root or fracture suspected

Have you stopped the bleeding?

1

Monitor ≥ 30 min

Quiet area. Re-check before discharge.

2

Instructions

No rinse/spit ≥ 6 h. Rest. No smoking/alcohol 24 h.

3

If restarts

Firm pressure $\pm$ TXA. Return to ED if not controlled.

4

Document

Findings, measures, observations, advice given.

Still bleeding?

Senior help

Second on-call or consultant

Advanced aids

Bipolar, bone wax

Medical teams

Haematology / ED physicians

Theatre

Uncooperative or torrential bleed

Warfarin

REVERSAL

- Vitamin K (IV preferred)
- 4-factor PCC (dose by INR/weight)
- FFP only if PCC unavailable
- Discuss with haematology

CAUTION

Do not reverse lightly.

The reason for anticoagulation is often high-risk.

Bridging with LMWH is frequently required after reversal until INR is therapeutic again.

DOAC reversal agents

Drug	Target	Reversal	Dose
Dabigatran	Thrombin	Idarucizumab	5 g IV
Apixaban	Factor Xa	Andexanet alfa	Low / high dose
Rivaroxaban	Factor Xa	Andexanet alfa	Low / high dose
Edoxaban	Factor Xa	Andexanet or PCC	PCC 25–50 IU/kg

DOACs — practical points

Local measures first

Most socket bleeds still settle with pack + suture alone.

Andexanet alfa

For apixaban / rivaroxaban.

Involve haematology

Shared decision. Document indication and restart plan.

Idarucizumab

Rapid, complete reversal of dabigatran. 5 g total.

PCC fallback

If andexanet unavailable use 4F-PCC 25–50 IU/kg.

Elective timing

Schedule when levels are lowest (skip morning dose of BD agents).

Other sources of bleeding

Ward post-op

Especially after LMWH given

Epistaxis

Merocel / Rapid Rhino packs

Haematoma

May need drainage

Lacerations

Closure usually sufficient

Oral tumours

Friable tissue — pack / diathermy

Mid-face trauma

Airway first, then sources

HAEMO framework



= HAEMOSTASIS

Six things to remember

- 1 Local measures first — most sockets settle with pack + suture
- 2 Be systematic: History → Assess → Treat → Monitor → Escalate
- 3 Know the agents: Warfarin → Vit K ; Dabigatran → Idarucizumab; FXa → Andexanet / PCC
- 4 Do not reverse lightly — discuss with haematology
- 5 Document clearly and give written post-op advice
- 6 Ask for help early — seniors, bipolar, theatre are available

Clinical Case

Referral re Appearance LR6



7 year old female

LR6 hypoplastic and mobile

Previous cheek haemangioma on cheek -
treated with laser

MRI no evidence of mandibular
haemangioma, suggested vascular
malformation right submandibular region

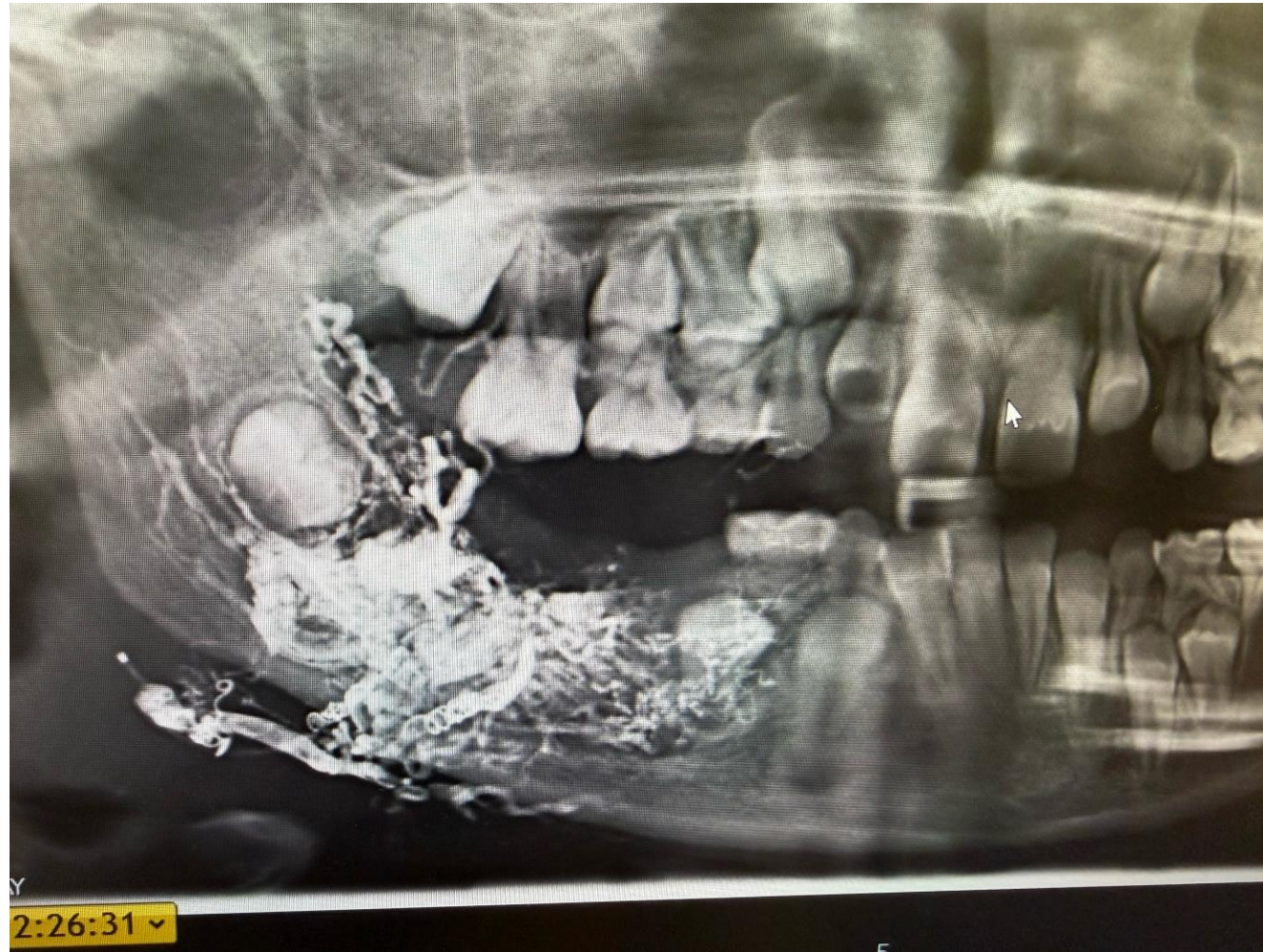
LR6 Extracted in Theatre

- Under GA due to young age
- Torrential bleeding
- Tooth replaced in socket
- Kept intubated, transfer to paediatric ICU
- Interventional radiology embolisation

CT Angiogram



AVM Sclerosed



Questions?

Safe haemostasis starts with a calm, systematic approach.

Always follow local hospital guidelines for reversal agents.