UPPER RESPIRATORY TRACT INFECTIONS
Dental Abscess

NHS111 may be contacted to find an emergency dentist if the patient is not currently registered at a dental practice.

Definitive and appropriate treatment can only be given **by a dentist** (e.g., drainage may be required). Medication will not eliminate the source of infection and serious complications can occur if the abscess is not treated correctly.

Emphasise that the patient must seek treatment from a dentist.

In the absence of immediate assessment and treatment by a dentist:

- Ensure patient does not have features of serious illness or complications requiring immediate hospital treatment.
- Provide appropriate self-care advice to reduce the pressure and pain of the dental abscess:
  - Use a soft toothbrush to reduce discomfort. Avoid flossing the tooth with the abscess.
  - Consume soft foods and eat on the other side of the mouth to reduce discomfort and irritation.
  - Avoid food or drink that may be too hot or cold.
  - Advise on the use of an analgesic to relieve symptoms:
    - Ibuprofen is recommended first-line (paracetamol if ibuprofen contraindicated or unsuitable).
    - Warn that analgesics should not be used to delay appropriate dental treatment.
  - NHS Patient Advice

Antibiotics are not generally indicated for otherwise healthy people with no signs of spreading infection.

- For most pulpal and periapical conditions, dental treatment and over the counter analgesia is the mainstay of treatment.
- **In the absence of immediate attention by a dentist**, ***only prescribe an antibiotic*** **(and ensure it is noted in the medical records)**:
  - For people who are **systemically unwell or if there are signs of severe infection (e.g., fever, lymphadenopathy, cellulitis, diffuse swelling)**.
  - For **high-risk individuals to reduce the risk of complications (e.g., immunocompromised, diabetic).**

When prescribing an antibiotic:

- Do not give repeated courses of antibiotics, or switch antibiotics in people who fail to respond to first-line treatment.
- Always consider an alternative diagnosis or the development of a complication in people with a suspected dental abscess who do not respond or become systemically unwell after first-line antibiotic treatment.
- Advise the person to seek urgent dental intervention rather than switching antibiotics or, if this is not available, seek advice from an oral and maxillofacial specialist.

Antibiotics for adults over 18 years if indicated (see above):

Antibiotic[1]	Dosage	Duration
First Choice		
Amoxicillin	• 500mg-1g TDS	5 days (review at 3 days)
Phenoxymethylpenicillin	• 500mg-1g QDS	5 days (review at 3 days)
Alternative first choices (if penicillin allergy or intolerance)		
Clarithromycin[2]	• 500mg BD	5 days (review at 3 days)
Consider concomitant treatment with metronidazole if the infection is severe or spreading (lymph node involvement, or systemic signs such as fever or malaise)		
Metronidazole	• 400mgTDS	5 days (review at 3 days)

[1] See BNF for appropriate use and dosing in specific populations, for example, hepatic impairment or renal impairment, and in pregnancy and breastfeeding.
[2] Withhold statins whilst on clarithromycin course.

Antibiotics for children and young adults under 18 years if indicated (see above):

Antibiotic[1]	Dosage[2]	Duration
First Choice		
Amoxicillin	• 1–5 years: 250mg TDS • 5–12 years: 500mg TDS • 12–18 years: 500mg TDS	5 days (review at 3 days)
Phenoxymethylpenicillin	• 1–6 years: 125mg QDS • 6–12 years: 250mg QDS • 12–18 years: 500mg QDS	5 days (review at 3 days)
Alternative first choices (if penicillin allergy or intolerance)		
Clarithromycin	• 1 month to 11 years: o Under 8kg: 7.5mg/kg BD o 8 to 11kg: 62.5mg BD o 12 to 19kg: 125mg BD o 20 to 29kg 187.5mg BD o 30 to 40kg: 250mg BD • 12 to 18 years: 250mg BD	5 days (review at 3 days)
Consider concomitant treatment with metronidazole if the infection is severe or spreading (lymph node involvement, or systemic signs such as fever or malaise)		
Metronidazole	• 1–3 years: 50mg every 8 hours • Child 3–7 years: 100mg every 12 hours • Child 7–10 years: 100mg every 8 hours. • Child 10–18 years: 200–250mg every 8 hours.	5 days (review at 3 days)

[1]See BNF for children for appropriate use and dosing in specific populations, for example, hepatic impairment and renal impairment.

[2] The age bands apply to children of average size and, in practice, the prescriber will use age bands in conjunction with other factors such as the severity of the condition and the child's size in relation to the average size of children of the same age. Doses given are by mouth using immediate-release medicines, unless otherwise stated.