

A review of dental surgical operations in 64 patients from a large haemophilia centre in Northern India

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OBJECTIVES

To assess the efficacy of haemostasis with combination protocol using anti-haemophilic factors (AHF) and local haemostatic agents, their outcome during the dental surgical operations carried out in the haemophilia patients.

METHODS

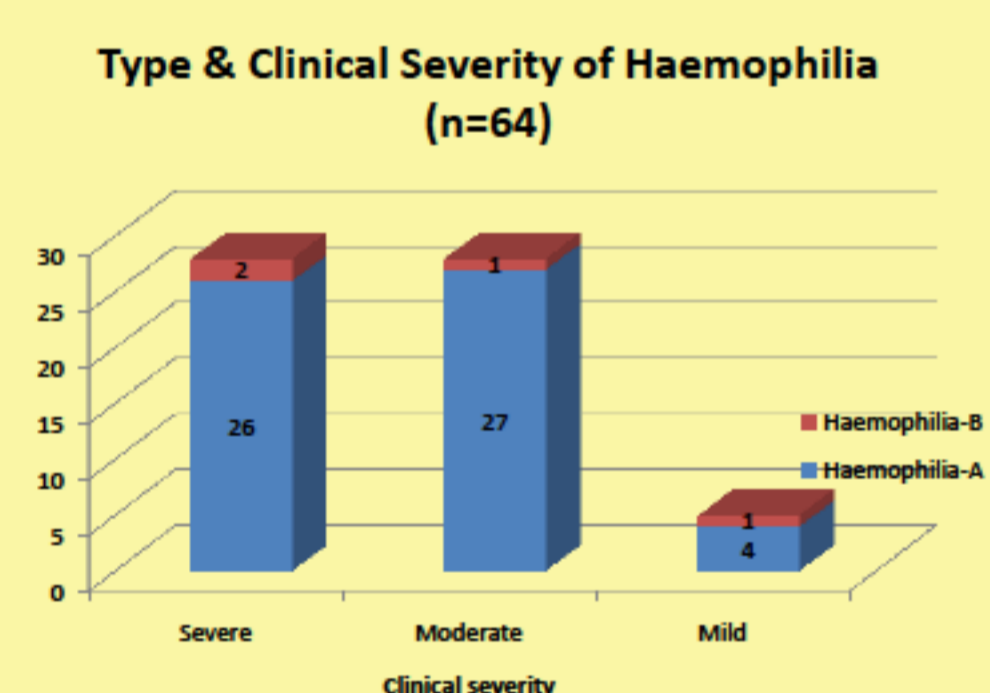
The Haemophilia Centre at Maulana Azad Medical College and Lok Nayak Hospital, New Delhi, India now has 1,156 registered haemophilia patients. This centre in collaboration with Maulana Azad Institute of Dental Sciences, located in the same campus, is involved in managing patients with dental problems requiring operative interventions. The designated dental surgeon had prior consultations and discussions with the haemophilia centre staff on the needs, the problems, and the treatment protocols for maintaining haemostasis.

All the 64 haemophilia patients requiring dental surgery for their problem of dental bleed /dental problem between May 2008 to Dec2011 were included for this study. All patients had a prior detailed clinical workup and diagnosis for haemophilia in our centre.

Prior to reporting to the dental department, patients received plasma-derived Factor VIII or Factor IX (Baxter) as per protocol in the Haemophilia Centre about 50 minutes before the pre-planned dental operative procedures which were performed by the designated expert dental surgeon in the dental OT. Haemostasis protocols were followed pre- and post-operatively. Patients were re-evaluated after surgery and observed for two hours in the haemophilia centre and discharged, if OK for haemostasis, on the antifibrinolytic tranexamic acid with follow-up visit was next day morning/ in emergency if so required.

OBSERVATIONS AND RESULTS

All the 64 haemophilia patients requiring dental surgical intervention had a prior detailed workup records in the Haemophilia Centre, in 3 cases the severity awaited confirmation. All patients tested negative for factor inhibitor screen.



Out of 64 patients, 58 patients were having haemophilia A and 6 haemophilia B.

Age range was 3-65 years, mean 16.3 with 78% under 20 years.

Diagnostic group	Nos.	Haemophilia	
		A	B
1 Caries tooth	25	24	1
2 Mobile deciduous tooth	24	21	3
3 Retained deciduous tooth	3	2	1
4 Periapical abscess	3	2	1
5 Impacted third molar	2	2	0
6 Fractured tooth	2	2	0
7 Adult permanent mobile tooth	1	1	0
8 Foreign body	1	1	0
9 Scaling	2	2	0
10 Curettage	1	1	0

Two patients had interventions twice, thus making total 66 surgeries in 64 patients. All surgeries were performed under local anesthesia.

Patients were infused single dose of anti-haemophilic factors (AHF) 50-60 minutes pre-operative. Antifibrinolytic tranexamic acid was administered locally to all, pre- and post-operative.

Successful hemostasis was achieved in all the 64 patients. Three patients presented with bleeding after extraction, which was attributed to the primary disease pathology coupled with tough intervention, otherwise these patients respond to well to AHF.

Mean AHF dose was 20.8 IU/kg, 80% receiving under 30 IU/kg. All but one received less than 42 IU/kg.

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CONCLUSIONS

1. Dental problems are common in haemophilia.
2. Frequent dental pathologies in young haemophilics were carious broken/exposed/decayed teeth and mobile deciduous teeth.
3. Single dose of AHF concentrate coupled with local antifibrinolytics produces sufficient haemostasis for most dental surgical interventions.
4. A dose of Factor concentrate 30 IU/Kg is adequate for 80% of routine dental procedures.
5. A close liaison between haemophilia centre and dental surgeon is essential for identifying and successfully managing the dental problems in haemophilia.

