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THE PEDIATRIC DENTAL REPORT

Your source for pediatric dentistry news



Can you name one thing almost everyone reading this note have in common?

Answer: A history of a herpes simplex infection.

We in pediatric dentistry see the age group most commonly associated with a primary herpetic infection. However, anyone who sees children has run across this malady.

One must always keep in mind that this is a contagious condition. With both primary and secondary presentations...

The typical patient for a primary infection is young, around 3 years old and presents with a fairly typical clinical appearance. But more about that later.

As a review, the herpes virus is a DNA virus. The oral infection is commonly associated the HSV1 variety. Primary herpetic gingivostomatitis is the initial infection which can range from sub-clinical to fairly significant in severity. Secondary herpes is a local reactivation of the virus that produces

a cold sore, and is seen typically in older patients.

The primary infection typically has an incubation period of 2-12 days. Usually a fever and sore throat along with small vesicle development on the pharyngeal and oral

mucosa marks the beginning. The vesicles ulcerate rapidly and can increase in numbers to involve the soft palate, tongue and floor of the mouth. Gingival tissue may bleed. Inflammation of lymph nodes and a general malaise are other common findings. Typical time of clinical expression is 10-14 days. Swollen salivary glands are slower to resolve. Parents usually will tell you there is great difficulty in eating, carry a temperature and their children have a hard time sleeping.

Treatment is usually palliative.

Caring for this dilemma involves treating the symptoms. Over the counter pain/anti-inflammatory/anti-pyretic medications can help the discomfort and lower an elevated temperature. Rinsing with a compounded formula of 50/50 Benadryl and Maalox 2-3 times a day can help soothe the oral lesions. The topical effect of the Benadryl is enhanced by the Maalox which coats and adheres to the mucosal tissue. Some textbooks recommend adding viscous lidocaine to the mixture, but you must be careful of approaching the toxic dose if swallowed by a small child. For a patient who cannot brush well due to the ulcerated oral mucosa, rinsing with liquid chlorhexidine (Peridex) 2-3 times a day can substitute for brushing for the short term. Typically a bland and soft diet is recommended. A most important point is to keep the patient hydrated. Caregivers should encourage fluids as much as possible. Popsicles or ice cubes can aid in comfort and help



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provide some oral liquid. Once a patient becomes dehydrated it is hard to play catch up, especially with a sick child. If dehydration is apparent or the symptoms do not resolve, IV fluids and further diagnostic work up may be necessary.

The gift that keeps on giving.

One must always keep in mind that this is a contagious condition. With both primary and secondary presentations, the blisters and ulcers are sources for viral shedding. Do not share utensils, wash hands frequently, and keep the child from rubbing their eyes after fingers of hands have been in their mouth.

Hydration, medication, re-evaluation.

Manage the patient by encouraging fluids,

recommending the appropriate dose of ibuprofen or acetaminophen, keep the oral area clean and comfortable, follow up for resolution of the infection. Normally we tell parents to expect a 10-14 day course. Anything longer than that warrants a re-diagnosis and further work up.

Need a consult?

For any inquiry on this topic or any patient you might have a question on, we are happy to provide advice over the phone.

You can review this discussion archived on our web site as well as view other pediatric dental topics on Kitsapdfc.com



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