

ACUTE GINGIVAL INFECTIONS



NUG



Primary herpetic gingivostomatitis



Pericoronitis

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Primary Herpetic Gingivostomatitis

- Clinical features
- Oral signs and symptoms
- Histopathology
- Differential diagnosis
- Treatment

Pericoronitis

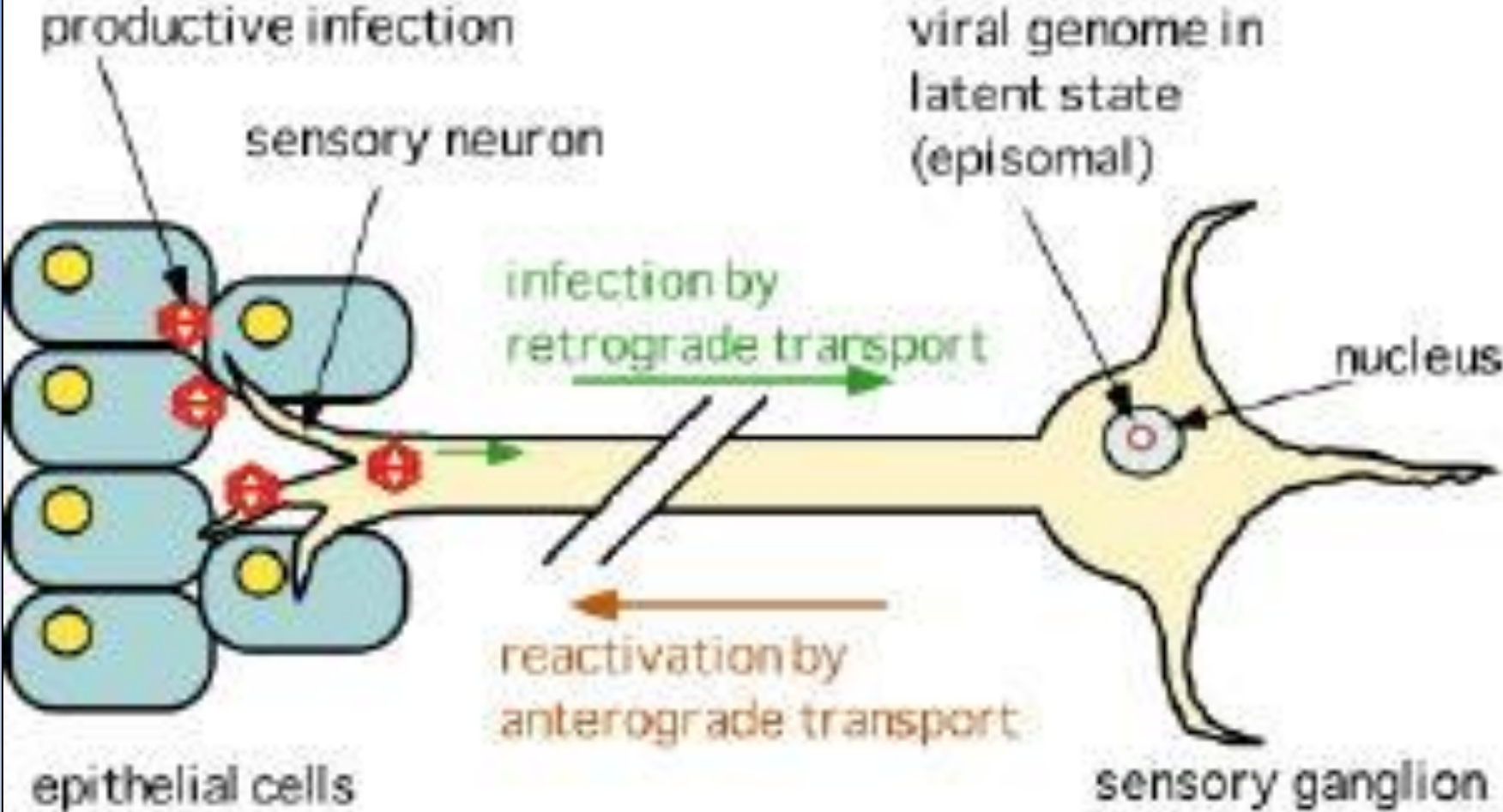
- Clinical features
- Complications
- Treatment

PRIMARY HERPETIC GINGIVOSTOMATITIS

- Caused by herpes simplex virus (**HSV – 1**)
- Most often in children **younger than 6 years** of age
- Mostly the primary infection is **asymptomatic**



HSV-1 Latency





Herpes labialis

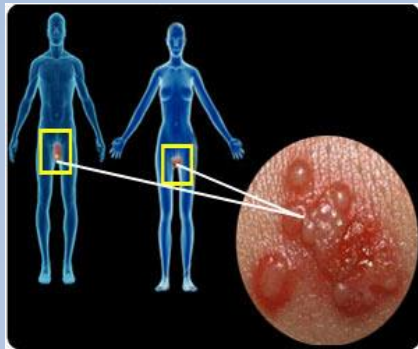


Herpes stomatitis

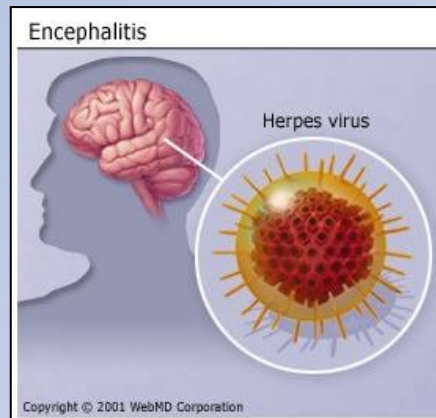


ocular herpes

SECONDARY MANIFESTATIONS



Herpes genitalis



Herpes encephalitis



Herpetic whitlow

HERPES LABIALIS

Stage 1 1 Day (Average Duration)



Tingling, itching, or burning beneath the skin (usually around the mouth or nose) may begin. **The first sensation is the ideal time to begin treatment.**

Stage 2 1-2 Days



Small red bumps begin to blister.

Stage 3 1-3 Days



The blisters fill with fluid, forming a full-scale cold sore.

Stage 4 1-3 Days



Blisters rupture, leaving shallow, reddish wounds. This is when cold sores are most contagious and painful.

Stage 5 4-14 Days



The lesion collapses, leaving a yellowish crust. The crust falls away, leaving a red, tender area.

Stage 6 4-14 Days



Redness and irritation fade as your immune system returns the cold sore to a dormant state.

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CLINICAL FEATURES

Oral Signs

- Diffuse, erythematous, shiny involvement of gingiva and adjacent oral mucosa
- Initial stage – **vesicles** in the oral cavity
- After 24 hours – **vesicles rupture** and form painful small ulcers
- Ulcers have a **red, elevated, halolike margin** and a **depressed, yellowish or grayish white central portion**
- May be widely separated or form clusters
- Course – **7 to 10 days**
- **No scarring** of ulcerations



Oral Symptoms

- Soreness of oral cavity
- Pain during eating, drinking and oral hygiene
- Children – Irritable and refuse to take food



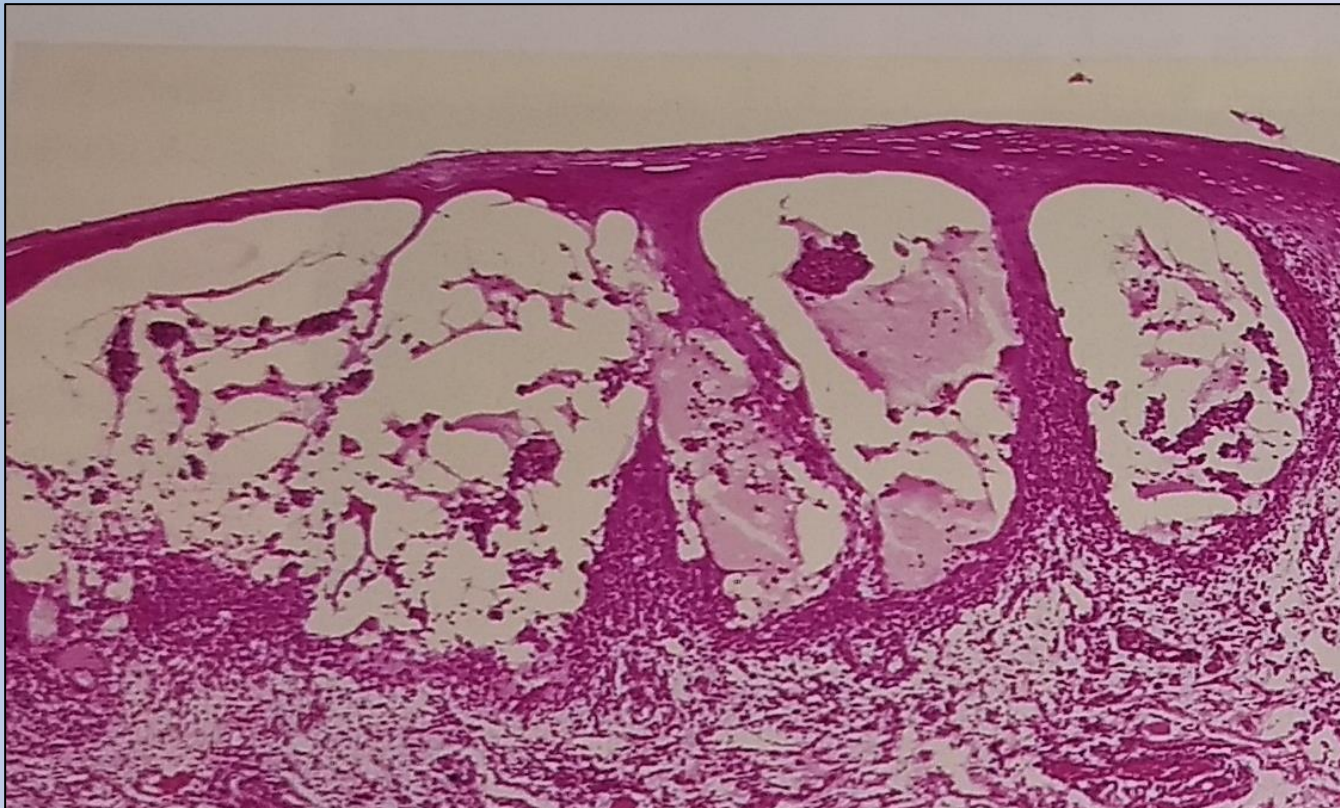
Extraoral Signs and symptoms

- Fever - 101° F to 105°F
- Cervical adenitis
- Generalised Malaise



HISTOPATHOLOGY

- Epithelial cells show **ballooning degeneration**
- **Tzank cells** - multinucleated giant cells



DIFFERENTIAL DIAGNOSIS

Necrotizing Ulcerative Gingivitis

Etiology: interaction between host and bacteria, most probably fusospirochetes

Necrotizing condition

Punched-out gingival margin; pseudomembrane that peels off and leaves raw areas

Marginal gingiva affected; other oral tissues rarely affected

Uncommon in children

No definite duration

No demonstrated immunity

Contagion not demonstrated

Primary Herpetic Gingivostomatitis

Specific viral etiology

Diffuse erythema and vesicular eruption

Vesicles rupture and leave slightly depressed oval or spherical ulcer

Diffuse involvement of gingiva; may include buccal mucosa and lips

Occurs more frequently in children

Duration of 7–10 days

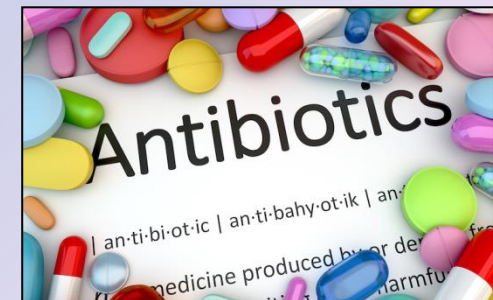
Acute episode results in some degree of immunity

Contagion



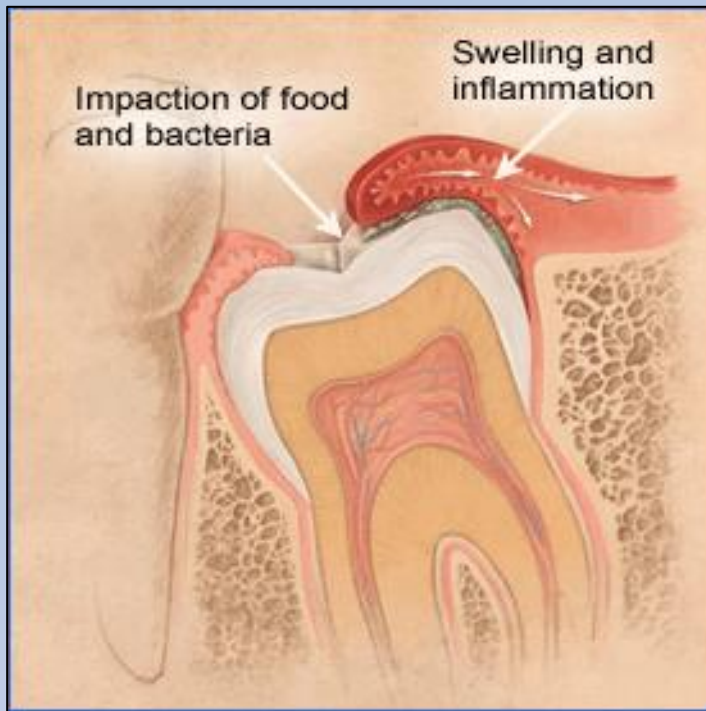
TREATMENT

- Early diagnosis and immediate treatment of antiviral therapy
- **Diagnosis within 3 days**
 - acyclovir suspension – **15mg/kg 5 times daily for 7 days**
- **Diagnosis after 3 days in immunocompetent individual**
 - Acyclovir therapy may not be very useful
 - Only palliative treatment
 - Fever and pain – **NSAIDs**
- **Topical anesthetics** – pain from ulcerations
- Removal of plaque and food debris
- **Local and systemic antibiotics** – to prevent opportunistic infection of the ulcers



PERICORONITIS

- Inflammation of the gingiva in relation to the crown of an incompletely erupted tooth
- Common sites – **Mandibular 3rd molars**
- Types – acute, subacute, chronic



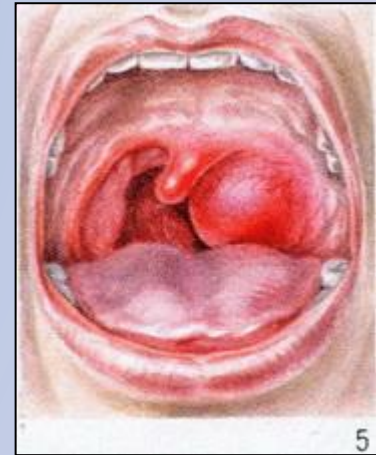
CLINICAL FEATURES

- **Red, swollen suppurating** lesion which is tender
- Pain can **radiate** to ear, throat and floor of the mouth
- Extremely uncomfortable – inability to close the mouth
- Trismus
- Swelling of the cheek
- Lymphadenitis
- Systemic signs
 - Fever
 - Leukocytosis
 - malaise



COMPLICATIONS

- Infection may spread
 - Posteriorly – oropharyngeal area
 - Medially – base of the tongue



Peritonsillar abscess



Pericoronar abscess



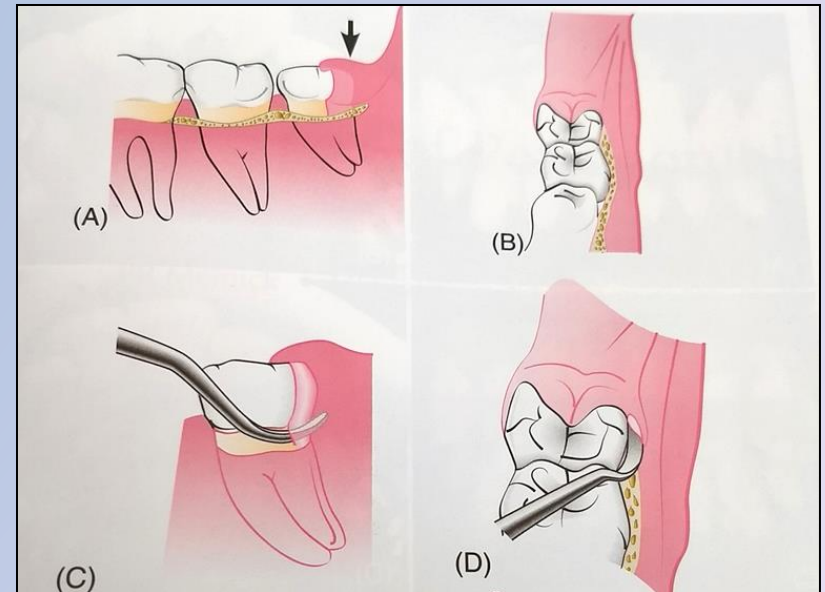
Cellulitis

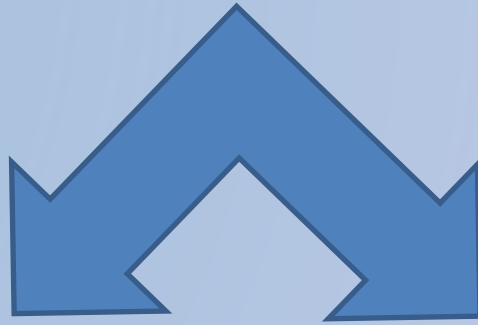


Ludwig's angina

TREATMENT

- Symptom free pericoronal flap
 - Removed to prevent acute involvement
- **Acute pericoronitis**
 - Flushing with warm water
 - Swabbing with antiseptic
 - Assessment of opposing tooth
 - Reduce soft tissue and/or
 - Adjust opposing tooth
 - **Antibiotics** - severe cases
 - **Incision and drainage** – pericoronal abscess
 - Decision to retain the tooth is taken after the acute symptoms subside



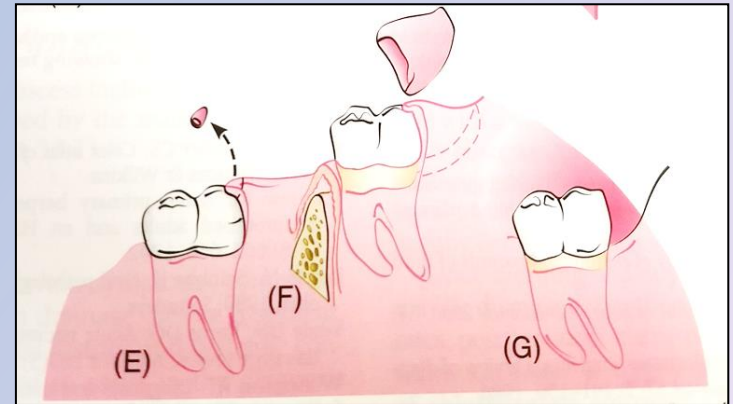


Extract

- Impacted
- Incorrect angulation
- Bone loss and caries distal to 2nd molar
- Absence of opposing 3rd molar



Retain the tooth



operculectomy

THANK YOU