

Orthodontics and Infective Endocarditis

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Abstract. *Infective endocarditis associated with orthodontics is a rare occurrence. Unfortunately, many orthodontic practitioners do not treat patients potentially at risk of developing endocarditis due to the lack of practical guidelines and fear of precipitating the infection. Additionally, many patients that undergo orthodontic treatment are inappropriately prescribed antibiotic cover for procedures that have a minimal bacteraemic risk. In this paper the literature linking orthodontic treatment and infective endocarditis is examined. Recommendations are made for the appropriate management of patients at risk of infective endocarditis for orthodontic procedures.*

Index words: Infective Endocarditis, Orthodontics.

Refereed Paper

Introduction

Infective endocarditis is a rare, but very serious complication of dental treatment. One necessary prerequisite for the development of infective endocarditis is a bacteraemia, which can develop as a result of dental treatment. Patients with conditions that predispose to the development of infective endocarditis need to be identified and given prophylactic antibiotics for dental treatment known to generate a bacteraemia. Most types of dental procedures, which are known to cause bacteraemias, have been investigated and guidelines for the prevention of infective endocarditis have been published (BSAC Working Party, 1992).

There is still confusion, however, as to what types of orthodontic procedures generate bacteraemias which could cause endocarditis in a susceptible patient. This has lead some orthodontists to be ultra-cautious and to not carry out orthodontic treatment in susceptible patients. It is the purpose of this paper to examine the link between orthodontics and infective endocarditis, and to make practical recommendations for practitioners.

The Link Between Orthodontic Treatment and Infective Endocarditis

The link between orthodontics and infective endocarditis has not been fully defined (Gaidry *et al.*, 1985; Hobson and Clark, 1995). Hobson and Clark (1995), in a survey of 1038 orthodontists, found only eight cases of infective endocarditis diagnosed during or immediately after orthodontic treatment involving both fixed and removable appliances. The paucity of reported cases could reflect the fact that very little orthodontic treatment has been done on patients susceptible to infective endocarditis. In fact, the converse is true, orthodontics is widely practised on patients susceptible to infective endocarditis both in Europe and U.S.A. It would necessarily follow that, since there is a paucity of cases, the risk between infective endocarditis and orthodontics must be very small. However, it is as yet unclear which clinical procedures in orthodontics

could potentially result in the development of endocarditis.

It has been postulated that placement of orthodontic bands could result in a bacteraemia. McLaughlin *et al.* (1996) were able to detect bacteraemias in 10 per cent of blood samples taken during band placement. One other study did not detect micro-organisms in the bloodstream during banding (Degling 1972). This apparent contradiction in detection rates may be a result of difficulties in the techniques of bacteraemia detection. It could also (and more likely) be due to the fact that banding does not always produce detectable bacteraemias that could cause infective endocarditis.

Cleaning and polishing of teeth has been associated with bacteraemias and infective endocarditis (Everett and Hirschmann, 1977; Martin *et al.*, 1997). Therefore, it follows that this procedure could put a predisposed patient at risk from infective endocarditis. In the opinion of the authors a direct corollary of this must be that antibiotic prophylaxis is required in susceptible patients for the placement and removal of bands, and any polishing of the teeth.

The adjustment of fixed or removable orthodontic appliances has never been associated with a risk of a significant bacteraemia or a proven case of infective endocarditis. It is for this reason that the American Heart Association, in their recent guidelines did not recommend prophylaxis for adjustment of orthodontic appliances (Dajani *et al.*, 1997). Similarly, the taking of impressions for study models is not associated with a significant bacteraemia (that could cause infective endocarditis) and does not require prophylactic antibiotics.

The exposure of teeth (particularly palatal canines) is a surgical procedure that would generate a bacteraemia and requires prophylactic antibiotics in patients susceptible to infective endocarditis. Once the tooth is exposed, the operative site may be considered in the same manner as an extraction site or erupting tooth, and does not require any further antibiotics. It has been argued that traction following excisional exposure may result in a reduced risk of bacteraemia compared to traction following replaced flap techniques (Hobson and Clark, 1995). This recommendation may be based on the potential for bacteraemia during the period of traction. In our opinion any tooth movement through a replaced flap is analogous to accelerated tooth eruption and should not require prophylactic antibiotics.

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Principles of Prophylaxis

Prophylaxis is sometimes interpreted as meaning antibiotic prophylaxis. However, it should also be concerned with the maintenance of good oral hygiene and prevention of oral disease. Poor oral hygiene results in plaque accumulation and a resultant quantitative increase in plaque bacteria. The subsequent gingival inflammation and spontaneous bleeding caused by broken capillaries will lead to transitory bacteraemias. Hence, placement of orthodontic appliances and gingival inflammation in such a situation will result in an increase in bacteraemic episodes.

Transitory bacteraemias have been induced in patients with clinically healthy gingivae (Silver *et al.*, 1977). Bacteraemias have also been demonstrated with toothbrushing in the presence of inflammation and plaque (Chung *et al.*, 1986), but the significant factor is that the bacteraemic load is reduced when oral hygiene is good. Silver *et al.* (1977) also showed that the percentage of positive cultures (a measure of the number of micro-organisms isolated) increased with increasing severity of inflammation. There are no reports of infective endocarditis being precipitated by oral hygiene procedures in patients with mouths that have a good gingival condition.

The number of micro-organisms in a bacteraemia is also influenced by the degree of trauma after a particular manipulative procedure (Bender and Barkan, 1989). It is on the basis of this finding that antibiotic cover is recommended for some procedures and not others (BSAC Working Party, 1992).

An effective method for reducing the level of bacteraemia is to use an oral rinse of 0.2 per cent (w/v) chlorhexidine solution (Stirrup *et al.*, 1981; Mcfarlane *et al.*, 1984). Repeated applications of chlorhexidine have not been found to result in changes in sensitivity to this disinfectant (Schlott 1976; Millns *et al.*, 1994). This is distinct from patients who have received long term antibiotics where resistant strains of oral Streptococci, the most common bacteria identified in bacterial endocarditis, tend to be present in the mouth (Longman *et al.*, 1992).

Patients at Risk from Endocarditis

The most important factor in the assessment of patients at risk from infective endocarditis is the patient's medical history. Patients can be divided into three types high, moderate or negligible risk. The medical conditions that are in each of the three categories are shown in Table 1. Patients at high risk can potentially undergo orthodontic treatment, but the patient's cardiologist should be consulted to assess risk before treatment. If, after consultation with the patient's physician, the risk of infective endocarditis is considered to be high then treatment should not be undertaken. Patients at moderate risk of endocarditis can receive orthodontic treatment and they will need antibiotic cover for procedures that cause bacteraemia. Patients at negligible risk can be treated without antibiotic prophylaxis, but again, the precise nature of the patient's condition should be confirmed with the physician prior to the start of treatment. Many potential orthodontic patients give a history of a heart murmur. This requires investigation and clarification of whether the murmur is innocent, prior to undertaking any orthodontic treatment.

TABLE 1 *Cardiac conditions associated with endocarditis (Dajani et al., 1997)*

High Risk

1. Prosthetic cardiac valves, including bioprosthetic and homograft valves.
2. Previous bacterial endocarditis.
3. Complex cyanotic congenital heart disease (e.g. single ventricle states, of the transposition of the great arteries, tetralogy of Fallot)
4. Surgically-constructed systematic pulmonary shunts or conduits.

Individuals with any of the above conditions are at a much higher risk for developing severe endocardial infection that is often associated with high morbidity and mortality.

Moderate Risk

1. Most other congenital cardiac malformations (other than those above or below).
2. Acquired valvular dysfunction (e.g. rheumatic heart disease).
3. Hypertrophic cardiomyopathy.
4. Mitral valve prolapse with valvular regurgitation and/or thickened leaflets.

Negligible Risk

1. Isolated secundum atrial septal defect.
2. Surgical repair of atrial septal defect, ventricular septal defect or patent ductus arteriosus.
3. Previous coronary artery bypass graft surgery.
4. Mitral valve prolapse without valvular regurgitation.
5. Physiological functional or innocent heart murmurs.
6. Previous Kawasaki disease without valvular dysfunction.
7. Previous rheumatic fever without valvular dysfunction.
8. Cardiac pacemakers and implanted defibrillators.

Antibiotic prophylaxis is recommended for the 'high' and 'moderate' risk categories, but not for the 'negligible' risk category. This latter category lists cardiac conditions in which the development of endocarditis is not higher than in the general population.

The Practicalities of Orthodontic Treatment in Patients at Risk from Infective Endocarditis and Management Recommendations

The patient's condition should be accurately understood before any treatment is stated and this may involve further confirmatory tests by the cardiologist (e.g. echocardiography). When the orthodontist is in possession of all this information then informed consent should be obtained from the patient and/or guardian as appropriate.

Figure 1 shows a practical scheme for treating orthodontic patients at risk from endocarditis. In the opinion of the authors, the treatment formulated in patients at high risk of endocarditis should be practical, achievable, and not over ambitious. As with all orthodontic patients, oral hygiene should be impeccable before any treatment is started. Oral hygiene of a high standard is especially important in patients at risk from infective endocarditis since the accumulation of plaque increases the risk of significant bacteraemias during treatment. If the patient's oral hygiene lapses during treatment then consideration must be given to the abandoning of the appliance treatment if the hygiene does not rapidly improve. Patients at 'high' or 'moderate' risk should receive prophylactic antibiotics for procedures known to be associated with a bacteraemia. Table 2 lists orthodontic procedures and the need for

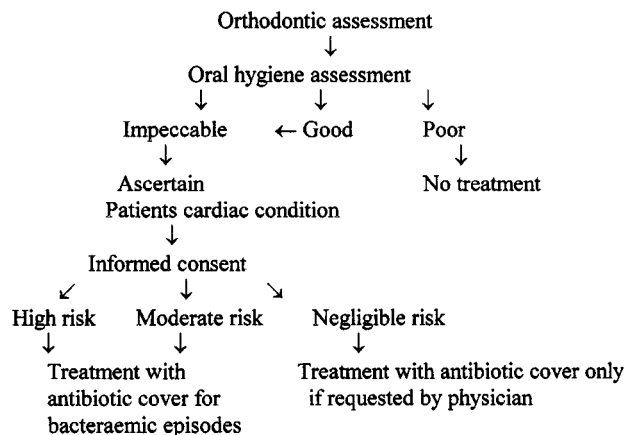


FIG. 1 A schema for the management of orthodontic patients at risk of infective endocarditis.

TABLE 2 The requirement for prophylactic antibiotics for orthodontic procedures in patients at high or moderate risk of infective endocarditis

Procedure	Need for antibiotic prophylaxis
Taking of impressions	No
Taking of radiographs	No
Separation	Yes
Cleaning and polishing prior to banding	Yes
Placement and adjustment of removable appliances	No
Placement of bands	Yes
Bonding of brackets	No
Placement of archwires with elastics or ligatures	No
Exposure of teeth	Yes
Application of traction to exposed teeth either with replaced or excised flaps	No
Mucosal trauma during archwire placement	Yes

antibiotic prophylaxis in the 'high' and 'moderate' risk categories. Table 3 details the currently recommended regimen for the prophylaxis of infective endocarditis.

Any orthodontic procedure in patients under any of the three risk categories should be done following a preliminary rinse with 0.2 per cent chlorhexidine mouthwash. Daily chlorhexidine rinsing should also be advised if mucosal irritation occurs which results in bleeding from the appliance. For effective prophylaxis, antibiotic therapy ideally should be administered within 2 hours of the procedure. In order to reduce the number of prophylaxis courses, fixed appliance placement should be completed in one visit. This is possible with banding and bonding without separation or preferably, the bonding of brackets on all teeth.

In all of the 'risk' categories, the patient must be instructed to report back any unexplained illness after the orthodontic procedure has been conducted (Samaranayake, 1995). There is still a possibility that infective endocarditis may occur despite appropriate antibiotic prophylaxis (Durack *et al.*, 1983; Van der Bijl and Maresky, 1991). This is said to be most likely within the first 30 days of the procedure (Van der Meer *et al.*, 1992), but due to the protracted nature of orthodontic treatment, the clinician should remain vigilant.

TABLE 3 Antibiotic regimens recommended for the prophylaxis of dentally-induced infective endocarditis (adapted from the Endocarditis Working Party of the British Society for Antimicrobial Chemotherapy, 1992, 1998)

No penicillin allergy	Allergic to penicillin
Local or no anaesthetic Amoxycillin 3 g orally 1 hour pre-operatively	Clindamycin 600 mg orally 1 hour pre-operatively
General anaesthetic Amoxycillin (3 g) and probenidol (1 g) or Amoxycillin (3 g) orally 4 hours pre-operatively and amoxycillin (3 g) post-operatively or Amoxycillin (1 g) IV at induction and 500 mg orally 6 hours later	These patients are classified as 'Special risk'
Special risk patients* Amoxycillin (1 g) IV and gentamycin (120 mg) IV, pre-operatively or at induction and amoxycillin (500 mg) orally 6 hours later	Teicoplanin (400 mg) IV and gentamycin (120 mg) IV pre-operatively or at induction or Clindamycin (300 mg) IV given over 10 min in 50 ml of diluent pre-operatively or at induction and 150 mg (oral or IV) 6 hours later or Vancomycin (1 g) slow IV infusion (over not less than 100 min) followed by gentamycin (120 mg) IV pre-operatively or at induction

* Or patients who have been prescribed penicillin more than once in the previous month.

Conclusions

The lack of reported cases in the literature, suggests that infective endocarditis associated with orthodontic treatment is extremely rare. Nevertheless, guidelines are necessarily based on the available scientific evidence, but unfortunately such evidence is scarce.

1. Patients can be divided into high, moderate, and negligible risk of infective endocarditis based on their medical condition.
2. Patients with a 'high' predisposition to infective endocarditis should only be treated after consultation with their supervising physician.
3. Patients at 'medium' risk can be treated but antibiotic prophylaxis should be considered only for procedures causing bacteraemias.
4. In the opinion of the authors, based on the available evidence, patients with a 'low' risk of infective endocarditis can be safely treated, usually without antibiotic prophylaxis. All patients should have a 0.2 per cent w/v chlorhexidine mouthwash prior to each adjustment.
5. Certain procedures are known to be associated with bacteraemias, these include band placement, removal of bands, and surgical exposure of teeth. Such procedures require antibiotic prophylaxis in 'at-risk' patients.

6. Clindamycin tablets should be swallowed with a glass of water to prevent oesophageal irritation.
7. Children under 10 years of age half the adult dose of amoxicillin or clindamycin is recommended and children under 5 years a quarter of the adult dose. For children under 10, 20 mg of vancomycin should be used and 2 mg of gentamycin. Children under 14 years of age should be given 6 mg/kg of teicoplanin plus 2 mg/kg of gentamycin.
8. For those patients not at special risk amoxicillin may be given twice in 1 month as it is unlikely that proliferation of clinically significant amoxicillin resistant strains will occur after one 3-g dose of amoxicillin. A third dose of amoxicillin, however, should not be given until after an interval of 1 month. A time interval of at least 2 weeks is required before clindamycin can be again used for prophylaxis.

Special Risk Patients

The British Society of Antimicrobial Chemotherapy have recognized a group of patients, with endocardial disease, who they consider as 'special risk'; these are considered to be particularly susceptible to infective endocarditis. Special risk patients are classified as those patients with endocardial disease who have had infective endocarditis or require a general anaesthetic and (a) have a prosthetic heart valve or (b) are allergic to penicillin or have had penicillin more than once in the previous month.

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