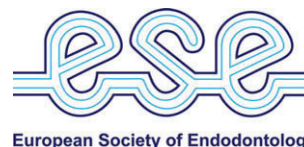


European Society of Endodontology position statement: the use of antibiotics in endodontics



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Abstract

European Society of Endodontology developed by: Segura-Egea JJ, Gould K, Hakan Şen B, Jonasson P, Cotti E, Mazzone A, Sunay H, Tjäderhane L, Dummer PMH. European Society of Endodontology position statement: the use of antibiotics in endodontics. *International Endodontic Journal*.

This position statement represents a consensus of an expert committee convened by the European Society of Endodontology (ESE) on Antibiotics in Endodontics. The statement is based on current scientific evidence as well as the expertise of the committee. The goal is to provide dentists and other healthcare workers with evidence-based criteria for when to use antibiotics in the treatment of endodontic infections, traumatic

injuries of the teeth, revascularization procedures in immature teeth with pulp necrosis, and in prophylaxis for medically compromised patients. It also highlights the role that dentists and others can play in preventing the overuse of antibiotics. A recent review article provides the basis for this position statement and more detailed background information (*International Endodontic Journal*, 2017, <https://doi.org/10.1111/iej.12741>). Given the dynamic nature of research in this area, this position statement will be updated at appropriate intervals.

Keywords: antimicrobial agents, apical periodontitis, endodontic infection, periapical periodontitis, pulpitis.

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Introduction

Endodontic infections, resulting in pulpitis or apical periodontitis, are polymicrobial, involving a combination of Gram-positive, Gram-negative, facultative anaerobes and strict anaerobic bacteria (Siqueira &

Roças 2014). Most endodontic infections are confined within the tooth and can be successfully managed by established local operative treatment (European Society of Endodontology 2006), drainage or tooth extraction without the need for local or systemic antibiotics. However, when there is evidence of systemic involvement and gross, rapid and diffuse spread of infection, antibiotics may be indicated as an adjunct to local treatment.

Prevention of bacterial contamination in traumatic injuries affects the prognosis of the affected teeth.

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Minimization of the bacterial load during the healing phase is beneficial in the management of injuries (Andreasen *et al.* 2006), and systemic or topical antibiotics can play an important role (<https://dentaltraumaguide.org/>).

The use of antibiotics to disinfect the root canal system has been commonplace in regenerative endodontic procedures (REPs) in immature teeth with necrotic pulps and apical periodontitis (Diogenes *et al.* 2013, Kontakiotis *et al.* 2015, Galler 2016). However, their continued use is being questioned (European Society of Endodontology 2016).

In healthy individuals, any bacteraemias generated by endodontic treatments are rapidly scavenged and cause no complications (Parahitiyawa *et al.* 2009), but in susceptible individuals, antibiotics can be given prophylactically to prevent local postoperative infections and metastatic spread of infection.

Systemic antibiotics in Endodontics

Indications for systemic antibiotics in Endodontics

Adjunctive systemic antibiotic treatment in conjunction with endodontic therapy is indicated in the following (Segura-Egea *et al.* 2017):

1. Acute apical abscess in medically compromised patients;
2. Acute apical abscess with systemic involvement (localized fluctuant swellings, elevated body temperature $>38^{\circ}\text{C}$, malaise, lymphadenopathy, trismus);
3. Progressive infections (rapid onset of severe infection in <24 h, cellulitis or a spreading infection, osteomyelitis) where onward referral to oral surgeons may be necessary;
4. Replantation of avulsed permanent teeth (Hinckfuss & Messer 2009, Segura-Egea *et al.* 2017). In these cases, topical administration of antibiotics may also be indicated (Andersson *et al.* 2012).
5. Soft tissue trauma requiring treatment (e.g. sutures, debridement) (Diangelis *et al.* 2012).

Contra-indications for systemic antibiotics in Endodontics

Most endodontic infections are confined within the tooth and can be successfully managed by established local operative treatment (European Society of Endodontology 2006), drainage or tooth extraction without the need for local or systemic antibiotics.

Thus, adjunctive systemic antibiotic treatment during endodontic therapy is not indicated in the following (Agnihotry *et al.* 2016, Segura-Egea *et al.* 2017):

1. Symptomatic irreversible pulpitis (pain, with no other symptoms and signs of infection);
2. Pulp necrosis;
3. Symptomatic apical periodontitis (pain, pain to percussion and biting and widening of periodontal ligament space);
4. Chronic apical abscess (teeth with sinus tract and periapical radiolucency);
5. Acute apical abscess without systemic involvement (localized fluctuant swellings).

From current knowledge (Segura-Egea *et al.* 2017) and based on the International Association of Dental Traumatology (IADT) guidelines (Andersson *et al.* 2012), antibiotic administration is not indicated in the treatment of tooth fractures, concussion, subluxation, luxation injuries and extrusion.

Types of antibiotics, recommended dosages and duration

Beta-lactam antibiotics (penicillin V and amoxicillin) are recommended for the treatment of endodontic infections (Segura-Egea *et al.* 2017) (Table 1). Antibiotics should be prescribed at the correct frequency, dose and duration so that the minimal inhibitory concentration is surpassed and so that side effects and the selection of resistant bacteria are prevented (Bax 2007). Recommended loading doses are 1000 mg of penicillin V administered orally followed by 500 mg

Table 1 Type, dosages and duration of antibiotics prescribed in Endodontics

Drug of choice	Loading dose	Maintenance dose	Duration
Penicillin VK ^a	1000 mg	500 mg q4-6h	3-7 days
Amoxicillin	1000 mg	500 mg q8h or 875 mg q12h	3-7 days
Amoxicillin with clavulanic acid	1000 mg	500 mg q8h or 875 mg q12h	3-7 days
Clindamycin ^b	600 mg	300 mg q6h	3-7 days
Clarithromycin ^b	500 mg	250 mg q12h	3-7 days
Azithromycin ^b	500 mg	250 mg q24h	3-7 days
Metronidazole	1000 mg	500 mg q6h	3-7 days

^aIf Penicillin VK alone is not effective after 48-72 h, metronidazole (loading dose 1000 mg followed by 500 mg q6 h) can be used in combination with penicillin VK or penicillin VK is switched to amoxicillin/clavulanic acid or clindamycin.

^bIf the patient is allergic to penicillin.

every 4–6 h (Segura-Egea *et al.* 2017), or 1000 mg amoxicillin, with or without clavulanic acid, followed by 500 mg every 8 h (Segura-Egea *et al.* 2017). If penicillin V is used and therapy is ineffective, the combination of penicillin V with metronidazole (loading dose 1000 mg followed by 500 mg every 6 h) or amoxicillin with clavulanic acid is recommended (Segura-Egea *et al.* 2017). When no response occurs, consultation with a specialist (clinical microbiologist, infectious disease specialist) will be necessary.

Beta-lactam antibiotics can cause allergy. If a true penicillin allergy is confirmed, alternatives are substituted: clindamycin (600 mg loading dose followed by 300 mg every 6 h), clarithromycin (500 mg loading dose followed by 250 mg every 12 h) or azithromycin (loading dose of 500 mg followed by 250 mg once a day) (Baumgartner & Smith 2009, Skučaitė *et al.* 2010, Segura-Egea *et al.* 2017). Clinical improvement in symptoms must be the guide for the duration of antibiotic treatment. As soon as the symptoms have resolved and there is clinical evidence of healing, the antibiotic therapy should be discontinued (American Association of Endodontists (AAE) 1999). Treatment duration of 3–7 days is often sufficient to control the infection, but patients should be seen after 2 or 3 days to determine whether treatment should be stopped or continued (Dar-Odeh *et al.* 2010). As part of general antibiotic stewardship, it is currently recommended to prescribe antibiotics for 3 days and review the patient; further antibiotics should only be prescribed if indicated clinically.

Topical antibiotics in Endodontics

There is no scientific evidence to support the use of topical antibiotics in pulp capping procedures or in root canal disinfection. Moreover, microorganisms isolated from root canals are resistant against tetracyclines (Skučaitė *et al.* 2010, Al-Ahmad *et al.* 2014) and their use may promote fungal growth (MacNeill *et al.* 1997) and cause discolouration of teeth when used as intracanal topical medicaments (Chen *et al.* 2012).

The antibiotic mixture composed of ciprofloxacin, metronidazole and minocycline (100 µg mL⁻¹ of each antibiotic, 300 µg mL⁻¹ of mixture) known as triple antibiotic paste (TAP) or '3mix' has been used as intracanal therapy to achieve disinfection and resolution of infection in regenerative endodontic procedures (Diogenes *et al.* 2013). However, the use of TAP containing minocycline as intracanal dressings in REP may cause dentine discolouration (Miller *et al.* 2012, Diogenes *et al.* 2013, Rodríguez-Benítez *et al.* 2015). The replacement of minocycline with cefaclor can reduce the risk of discolouration (Miller *et al.* 2012). However, the ESE position statement on revitalization procedures advocates the use of calcium hydroxide instead of antibiotics to avoid discolouration (European Society of Endodontology 2016). In the absence of strong evidence to support the use of antibiotics in regenerative endodontic procedures, their use should be avoided (Galler 2016).

After avulsion of immature teeth with open apices, topical application of tetracyclines (minocycline or

Table 2 Indications of antibiotics prophylaxis in Endodontics

Patient group	Indications
Impaired immunologic function (Leukaemia, HIV/AIDS, end-stage renal disease, dialysis, uncontrolled diabetes, chemotherapy, steroids or immunosuppressive post-transplant medications or inherited genetic defects)	Nonsurgical root canal treatment and, especially, endodontic surgery, considering: <ul style="list-style-type: none"> • State and control of the disease • Risk of infection-related complications • Risk of adverse drug reaction If doubt, the management of patient should be discussed with a physician
Risk of developing infective endocarditis (Patients with complex congenital heart defects, prosthetic cardiac valve or a history of infective endocarditis)	Nonsurgical root canal treatment Endodontic surgery
Prosthetic joint replacement	Nonsurgical root canal treatment Endodontic surgery During the first 3 months after joint operations
Patients whose jawbones are exposed to high-dose irradiation	Nonsurgical root canal treatment Endodontic surgery
Patients receiving intravenous bisphosphonate treatment	Endodontic surgery

Please consult local guidelines as these indications may vary from country to country.

Table 3 Recommended antibiotic prophylaxis regimens in Endodontics

Patient group	Antibiotic	Route	Dose		Timing before procedure
			Adults	Children	
Standard general prophylaxis	Amoxicillin	PO	2 g	50 mg kg ⁻¹	1 h
Unable to take oral medication	Ampicillin	IV o IM	2 g	50 mg kg ⁻¹	Within 30 min
Allergic to penicillin	Clindamycin	PO	600 mg	20 mg kg ⁻¹	1 h
	Cephalexin or cefadroxil	PO	2 g	50 mg kg ⁻¹	1 h
Allergic to penicillin/amoxicillin/ ampicillin and unable to take oral medications	Azithromycin or clarithromycin	PO	500 mg	15 mg kg ⁻¹	1 h
	Clindamycin	IV	600 mg	20 mg kg ⁻¹	Within 30 min
	Cefazolin	IV	1 g	25 mg kg ⁻¹	Within 30 min

Some countries may recommend other antibiotic regimens. Please consult local Guidelines.

doxycycline, 1 mg per 20 mL of saline for 5 min) onto the root surface before reimplantation increases the chance of root canal revascularization and periodontal healing, reducing the incidence of tooth resorption (Andersson *et al.* 2012).

Antibiotic prophylaxis in Endodontics

The use of prophylactic antibiotics in medically compromised patients undergoing endodontic therapy is controversial and should only be considered when the benefit has been demonstrated or when there is consensus for such use (Lockhart *et al.* 2007, Segura-Egea *et al.* 2017). In all treatment situations (Table 2), particularly in surgical endodontic treatment, an overall medical assessment must be based on the individual case, considering the state and control of the disease, the risk of infection-related complications and the risk of an adverse drug reaction. In cases of doubt, patient management should be discussed with a physician prior to endodontic treatment (Segura-Egea *et al.* 2017).

Antibiotic prophylaxis should be considered in individuals who are at risk of developing infective endocarditis following an invasive dental procedure, such as patients with complex congenital heart defects, prosthetic cardiac valves or a history of infective endocarditis (Wilson *et al.* 2007, Richey *et al.* 2008, Nishimura *et al.* 2008). The definition of invasive dental procedures includes all dental treatments requiring manipulation of the gingival or periapical region of the teeth or perforation of the oral mucosa and root canal procedures (European Society of Cardiology 2015).

Antibiotic prophylaxis before endodontic therapy is not indicated routinely for healthy patients after prosthetic joint replacement (Berbari *et al.* 2010, Skaar

et al. 2011, Sollecito *et al.* 2015). However, during the first 3 months after joint operations, antibiotic prophylaxis should be considered (Segura-Egea *et al.* 2017).

Endodontic treatment in patients whose jawbones are exposed to high-dose irradiation for cancer treatment in the head and neck should be preceded by antibiotic prophylaxis (Tolentino Ede *et al.* 2011, Segura-Egea *et al.* 2017).

Patients receiving intravenous bisphosphonate treatment warrant antibiotic prophylaxis in bone invasive procedures, such as endodontic surgery (Dannemann *et al.* 2007, Montefusco *et al.* 2008).

The recommended prophylaxis regimen is presented in Table 3; however, please note that some countries may recommend other antibiotic regimens. Please consult local Guidelines.

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Conflict of Interest

The European Society of Endodontology and the authors state explicitly that there are no conflict of interests related to this ESE position statement.

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