**Acute Gingival Infections**

 **(Part 2)**

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**2-Primary herpetic gingivostomatitis**

Primary herpetic gingivostomatitis is an infection of the oral cavity caused by the herpes simplex virus type 1 (HSV-1). It occurs most often in infants and children younger than 6 years of age, but it is also seen in adolescents and adults. It occurs with equal frequency in male and female patients.

The primary infection in most persons is asyptomatic, but as a part of the primary infection, the virus ascends through nerves, where it persists as latent HSV in neuronal ganglia that innervate the site, secondary manifestations result from various stimuli such as sunlight, trauma, fever, and stress. These secondary manifestations include herpes labialis, herpetic stomatitis, herpes genitalis, ocular herpes, and herpetic encephalitis.

 Secondary herpetic stomatitis can occur on the palate, gingiva, or on the mucosa as a result of dental treatment that traumatizes or stimulates the latent virus in the ganglia innervating the area.

**Oral Signs**

* In its initial stage, it is characterized by the presence of discrete, spherical gray vesicles, which may occur on the gingiva, labial and buccal mucosae, soft palate, pharynx, sublingual mucosa, and tongue.
* After approximately 24 hours, the vesicles rupture and form painful, small ulcers with a red, elevated, halo-like margin and a depressed, yellowish or grayish white central portion. These occur either in widely separated areas or in clusters where confluence occurs.
* Occasionally, primary herpetic gingivitis may occur without overt vesiculation. The clinical picture consists of diffuse, erythematous, shiny involvement of the gingiva and the adjacent oral mucosa, with varying degrees of edema and gingival bleeding.
* The course of the disease is limited to 7 to 10 days. Scarring does not occur in the areas of healed ulcerations.

**-Symptoms**

The disease is accompanied by generalized soreness of the oral cavity, which interferes with eating, drinking, and oral hygiene. The ruptured vesicles are the focal sites of pain

**- Treatment**

Consists of palliative measures to make the patient comfortable until the disease runs its course.

1-Plaque, food debris and superficial calculus are removed to reduce gingival inflammation, which complicates the acute herpetic involvement.

 Extensive periodontal therapy should be postponed until the acute symptoms subside to avoid the possibility of exacerbation.

2-For symptomatic relief, especially before meals, topical local anesthetic, such as lidocaine hydrochloride viscous solution can be applied to the affected areas. Before each meal the patient should rinse with 1 tablespoon of this solution.

3- If the patient is experiencing pain of longer duration, aspirin or a nonsteroidal anti-inflammatory agent can be given systemically.

4-Local or systemic application of antibiotics is sometimes advised to prevent opportunistic infection of ulceration. This is especially true in the immune compromised individual.

If the condition does not resolve within a 2-week period, the patient should be referred to a physician for medical consultation.

**3-Pericoronitis**

The term pericoronitis refers to inflammation of the gingiva in relation to the crown of an incompletely erupted tooth. It occurs most often in the mandibular third molar area. Pericoronitis can be acute and chronic.

**Clinical Features**

* The partially erupted or impacted mandibular third molar is the most common site of pericoronitis.
* The space between the crown of the tooth and the overlying gingival flap (operculum) is an ideal area for the accumulation of food debris and bacterial growth.
* Acute inflammatory involvement is a constant possibility and may be exacerbated by trauma, occlusion, or a foreign body trapped underneath the tissue flap.
* The inflammatory fluid and cellular exudate increase the bulk of the flap, which then may interfere with complete closure of the jaws and can be traumatized by contact with the opposing jaw, aggravating the inflammatory involvement.
* The resultant clinical picture is a red, swollen, suppurating lesion that is tender, with radiating pains to the ear, throat, and floor of the mouth.
* The patient is extremely uncomfortable because of a foul taste and an inability to close the jaws, in addition to the pain.
* Swelling of the cheek in the region of the angle of the jaw and lymphadenitis are common findings.
* Trismus may also be a presenting complaint.
* The patient may also have systemic complications such as fever, leukocytosis, and malaise.

**Treatment of acute pericoronitis**

1-Gently flushing the area with warm water to remove debris and exudate and

2- Swabbing with antiseptic after elevating the flap gently from the tooth with a scaler. The underlying debris is removed, and the area is flushed with warm water .

3-Antibiotics can be prescribed in severe cases.

4-If the gingival flap is swollen and fluctuant, an anteroposterior incision to establish drainage is made with a #15 blade.

-After the acute symptoms have subsided, a determination is made as to whether the tooth is to be retained or extracted.

 **If it is decided to retain the tooth**, the pericoronal flap is removed using periodontal knives or electrosurgery .

It is necessary to remove the tissue distal to the tooth, as well as the flap on the occlusal surface. Incising only the occlusal portion of the flap leaves a deep distal pocket, which invites recurrence of acute pericoronal involvement.

After the tissue is removed, a periodontal pack is applied.

The pack may be retained by bringing it forward along the facial and lingual surfaces into the interproximal space between the second and third molars. The pack is removed after 1 week.

**“Everything negative – pressure, challenges – is all an opportunity for me to rise.”**

 **— Kobe Bryant**