Table 5. Summary of Additional Precautions in Active and Suspected TB

Additional precaution	Comment
Minimise aerosol	Avoid handpieces with water spray Turn on high volume suction prior to handpieces (if necessary) Use rubber dam when possible
Environment	Negative pressure room (ideal) Well ventilated, not with air conditioning
Personal protection	FFP3 face mask Promote respiratory hygiene
Timing	Infection risk is significantly reduced after the completion of 2 weeks of TB therapy End of the session to minimise risk of transmission Keep waiting time in public area minimal
Team	Vaccinated members of staff
Modality	May be limited to treatment under local anaesthesia Treatment under conscious sedation or general anaesthesia warrants further discussion with local infection control and anaesthetic teams

(Courtesy of Clough S, Shaw A, Morgan C: Tuberculosis and oral healthcare provision. *Br Dent J* 224:931-936, 2018.)

New patients should also be screened. They should complete a medical and social history and update the information regularly.

Treating a Patient with TB

When TB is suspected or confirmed in a patient, special attention must be paid to areas such as personal protection, decontamination, and treatment concerns. With respect to personal protection, health care professionals should observe basic cough etiquette to reduce transmission risks. It's also important to ensure infection control procedures are followed, which should include hand hygiene, wearing gloves and clothing with access to the forearms, and using disposable aprons, eye protection, and face masks. With respect to decontamination of medical equipment, no instances have documented TB transmission related to medical equipment.

Treatment with the patient under conscious sedation or general anesthesia is often too complex for patients with active pulmonary TB. Should general anesthesia be required, planning with an anesthetic aide, theatre staff, and additional care options to manage humidification of the breathing system or other special measures must be part of the process (Table 5).

If the treatment will be delivered with local infection control and anesthetic teams, the patient must be monitored for respiratory depression and the need for increased oxygenation. The dentist should ensure that the patient is not given medications that might interact with concurrent TB treatment.

Clinical Significance

Countries such as the United Kingdom are seeing a resurgence in the occurrence of TB and having to deal with the public health problems that result from this development. The dental team should be prepared to manage this infectious disease, as well as all the others that patients may have, and follow proper protocols in all cases. If the dental practice works with especially vulnerable groups of patients in high-risk areas, proper equipment should be on hand to help in managing patients with active infection and to ensure that transmission to either other dental team members or other patients does not occur.

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Eating disorders

BACKGROUND

Eating disorders (EDs) are considered psychiatric problems and result from a complex interplay of factors. The major disorders in this classification are anorexia nervosa (AN), which is characterized by a body mass index (BMI) under 17.5 Kg/m^2 and a sustained loss of weight, and bulimia nervosa (BN), which is defined as a BMI above 17.5 Kg/m^2 and recurrent episodes of binge eating. Both AN and BN can be subdivided into a restrictive type, where the weight loss is accomplished through food intake reduction, prolonged fasting, and excessive physical activity, or a purgative type, which is characterized by the use of laxatives, diuretics or appetizer suppressors, or vomiting induction to achieve weight loss. Among the oral manifestations of both AN and BN are tooth decay, dentin hypersensitivity, dental abrasion, dental attrition, sialoadenosis, and hyposalivation, although there have been conflicting results concerning these manifestations' prevalence, reversibility, and association with ED subtypes and exacerbation periods. Most studies of ED patients have focused on inpatient groups, with little known about the relevance of ED subtype classification and conduct, especially the vomiting behavior, among outpatients. A study of the oral health behavior and orofacial problems seen in an outpatient group of patients with AN or BN was done, focusing specifically on the influence of vomiting.

METHODS

Thirty-three women outpatients undergoing psychotherapy for EDs and 33 matched volunteers who constituted the control group were evaluated. All completed the Eating Disorder Examination Questionnaire (EDE-Q), then an individual questionnaire designed to detect and evaluate possible factors affecting oral health. Patients were divided into those who exhibited vomiting behavior and those who did not for each disorder. All patients underwent a dental examination as well as an assessment of the decayed-missing-filled tooth (DMFT) and decayed-missing-filled surface (DMFS) indexes. Dental erosion, dentin hypersensitivity, periodontal status, xerostomia, and burning mouth feeling, as well as other oral disorders, were also evaluated to determine each individual's oral status.

RESULTS

Sixteen patients (48.5%) of the patients engaged in vomiting (VG group), with 10 diagnosed with AN and 6 with BN. Eleven of the BN patients used laxatives and were included in the non-vomiting group (NVG group). Evaluations found that significantly higher values of DMFT, DMFS, tooth decay, dental erosion, and self-reported hypersensitivity were characteristic of the ED group compared to controls. Dental erosion was strongly correlated with vomiting behavior, with significantly higher levels found in the VG group than the NVG group. Self-reported dentin hypersensitivity and active decay parameters were significantly higher for the ED group, regardless of their vomiting behavior or lack thereof, compared to the control group.

For periodontal-related parameters, the groups showed no difference in gingivitis prevalence between the control and ED groups. However, a significantly more common prevalence of periodontitis was seen among the ED patients than in the controls.

Xerostomia and hyposalivation were strongly related to ED. Self-reported difficulties during oral function was common in the ED group. This showed no relationship to the vomiting behavior.

Both angular cheilitis and burning mouth feeling were significantly more common among the ED group and were significantly higher among the VG group. Exfoliative cheilitis, fissured tongue, and lichen planus occurred with equal frequency among the control and ED groups. None of the patients or controls suffered from actinic cheilitis, oral candidiasis, or soft palate lesions.

DISCUSSION

The ED outpatients had significantly increased DMFT, DMFS, and tooth decay scores than the control group regardless of their vomiting behavior. Dental erosion and dentin hypersensitivity were also more common in the patients who had ED. Xerostomia, hyposalivation, and self-reported difficulties with oral function were more common among the ED patients than among the controls. Gingivitis did not differ between the 2 groups, but periodontitis was significantly more common among the ED patient group than in controls. Interestingly, the oral manifestations in ED outpatients were remarkably similar to the findings in inpatient ED patients in terms of diversity and severity.

Clinical Significance

The oral alterations found in ED outpatients highlight the important role that oral health care professionals can play in the management of persons who suffer from EDs. These professionals are in a position to be able to identify and refer patients with suspicious conditions for care early in the process of ED development. They may help these individuals achieve a better outcome in ED-related psychological and somatic treatment scenarios.

Lourenço M, Azevedo Á, Brandão I, et al: Orofacial manifestations in outpatients with anorexia nervosa and bulimia nervosa focusing on the vomiting behavior. *Clin Oral Invest* 22:1915-1922, 2018

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