

New Treatment Of A Dry Socket

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Citation

B Rai, R Jain, S Anand. *New Treatment Of A Dry Socket*. The Internet Journal of Dental Science. 2006 Volume 5 Number 1.

Abstract

Dry socket is a post operative complication that occurs after a dental extraction. The first time that this term appeared in the literature was in 1896, used by Crawford¹. It has been reported that the alveolar bone is exposed to bacterial contamination.² This exposition of socket walls occurs are to disturbance of the organization of blood clot and replacement by granulation tissue. The frequency of appearance of dry socket has been reported in a very wide margin from 1% to 70%.³ It is generally accepted the most dry socket appear after extraction of third molars, in which the occurrence of this complication is about 20-30% of dental extractions, ten times more than in rest of dental extraction.⁴ The recent studies have detected different risk factors in the development of dry socket. The difficulty of the dental extraction, the use of oral contraceptives, the surgeon's inexperience, an inadequate intra operatory irrigation, advantage of patients, female, tobacco, immunosuppression and surgical trauma.^{5,6,7,8}

It is clinically recognizable by the existence of a naked alveolus without presence of sanguine clot, exposed bony walls and separation of gingival borders. After a dental extraction, the sanguine clot gets lost in a premature, first way adopting a grizzly coloration, it stops later and disappears completely.^{3,4} Although suppuration is not evidenced, a very important, sharp and strong pain persists that increases with the suction or the mastication which lasts several days. It is not rare pain irradiation to the ear and the homolateral side of the head. Though rarely, it has also been reported the appearance of lymphatic nodes.^{6,8} The affection has its typical appearance on the second or third day after extraction, and it usually lasts, either with or without treatment about ten or fifteen days. Radiological studies do not show important alternations. The main etiopathogenic theories birn's fibinolitic theory and bacterial theory that have intended to explain the dry socket to understand the different preventive strategies. The purpose of this paper update the treatment and new technique of treatment of dry

socket.

MATERIAL AND METHODS

More than 420 patient of dry socket was treated by the authors from 1963 till date.

According to this technique the socket was irrigated with betadine and normal saline. The socket was curettaged for induced bleeding leading to clot formation. Suture the buccal and lingual gingiva. The pain delivered within 3-4 hours. Follow up of patients 3,9,12 months, 1, 2, 3 years respectively. No postoperative complication was detected.

DISCUSSION

The anti fibrinolytic agents are used in order to avoid the early disintegration of the clot.¹⁰ The use of soothing dressing has also been applied with success in the reduction of the post extraction dry socket.¹¹ The drugs that have probably been more successful in the prevention of socket are the antiseptic and the antibiotics. Such as tetracycline, metronidazol, clindamycin, penicilin, chlorohexidine etc.¹² The antifibroltic agents such as tranamic and, propilic ester of the p-hidroibenzoico acid are used in order to avoid the early disintegration of the clot.¹⁰

It was reported that complication curettage in acute and chronic condition remain the same.¹⁶ after the above literature this new technique was started by Prof. Brig S.C. Anand No osteomyelitis complication was detected. It effective due to clot formation was induced i.e. ischemic effect.

The pasts would diminish the patient's uneasiness during the recovery of the dry socket. Although the literature does not show clear evidences in favour of the placement of these pastes, they can help in treatment of dry socket.

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