You can't be too careful

Take a full assessment of a patient's medical history or there may be unnecessary complications.

A young adult female patient with a congenital heart defect and an imminent date for cardiac surgery attended a new practice (practice A), as she had become dissatisfied with her dental care elsewhere. Tooth UL7 was grossly carious, painful and required extraction. The patient was on warfarin and had been prescribed a course of antibiotics for dental infection by her previous dental practitioner.

A periapical radiograph was taken and in an attempt to accommodate the patient's request for extraction prior to the impending surgery, an urgent appointment was arranged for her at the end of the day.

The patient's international normalised ratio (INR) had historically been stable between the levels of two and four, but was not checked in the 72 hours prior to the scheduled dental extraction. The clinical records also did not demonstrate that careful radiographic evaluation had taken place.

The extraction procedure was fraught with difficulties, and after 50 minutes it became apparent that the functionless UL8 was acting as an obstacle and would also need to be extracted. The patient was told of the complication and provided verbal consent to the extraction while in the chair.

A second dentist was called into the surgery to assist with the procedure and the extraction of both UL7 and UL8 was completed after a further 20 minutes. Haemostasis was achieved prior to the patient leaving the surgery.

In the postoperative period, the patient had a bleed at home and contacted the surgery as a dental emergency. Unfortunately, however, the practice emergency system did not pick up the call. The patient therefore had no option but to attend the local hospital where she was kept for over eight hours until deemed fit to leave. During this time, the wound was cleaned, packed and sutured by the on-call clinician.

Practice A later received a letter of complaint from the patient, which raised issues around a lack of consent for the extraction of tooth UL8, and explained that she would not have agreed in advance to the extraction of a wisdom tooth so close to her cardiac surgery. Overall, the patient felt badly let down, and was very critical of the treatment received, the alleged poor clinical care and poor after care. She demanded a full refund.

Learning points

This case highlights the importance of the following:

- thorough preoperative assessment with due regard to anticoagulant medication;
- awareness that antibiotics may alter the INR level – ideally an INR record should be available in the 24 hours prior to the procedure if there is any suspicion of instability;
- being aware of the optimum timing of extraction procedures in patients who are likely to bleed; and,
- when endeavouring to accommodate patients, there is nothing to be gained by taking shortcuts; if complications arise, you will likely attract criticism.

Outcomes

There are vulnerabilities in this case with regard to the above and additionally in relation to:

- the quality of the preoperative case assessment and a careful consent process;
- the quality of the actual clinical care provided;
- the sufficiency of the clinical records, and the lack of written evidence of radiographic evaluation; and,
- the practice's out-of-hours emergency arrangements.

Had the patient pursued this matter, there were multiple vulnerabilities that could have resulted in further scrutiny and stress for the dentist. Fortunately, after a consultation with Dental Protection, a swift, empathetic response to the patient was sufficient to defuse the matter. The practice's response included a full apology with an expression of sincere regret and a full refund of the private fees. The patient was also reassured that action was taken within the practice to improve the emergency system, with the aim of preventing a similar situation happening again. The patient's cardiac surgery proceeded as scheduled.

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