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Prevention of the Inflammatory Complications

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Summary. Conducting of prophylactic antibiotic therapy in patient after surgical interventions in oral and maxillofacial surgery reduces the incidence of postoperative infectious complications. The general questions of prophylaxis, oral microflora are considered. Recommendations on the antibiotic prophylaxis in oral and maxillofacial surgery are given.

Keywords: antibiotics, prophylaxis, microflora, «stepped» antibiotic therapy, inflammatory complications, oral and maxillofacial surgery.

Recently, a number of patients with purulent-inflammatory complications in maxillofacial region is critically increased and the clinical course of the disease is aggravated. Despite of all comprehensive achievements of medicine the problem of inflammatory complications which manifests after performed operative interventions, is still actual. The frequency of postoperative wounds suppuration is directly dependent on the degree of purity of the surgical wound. It should be noted that after performance of the «clean» operations (removal of tumors, dental implantation, etc.) the incidence of infectious complications also remains at a high level. Clinical observation revealed that in the case of «clean» surgeries it is impossible completely eliminate the cases of suppuration of postoperative wounds. Despite the fact that performing of measurements associated with asepsis is obligatory in medical institutions, we cannot exclude microbial contamination of the surgical wound, because both the patient himself and the operating team may be a source of microbial contamination. Postoperative inflammatory complications should be considered as a factor leading to the significant aggravating of the postoperative period, and it increases the patient's risk of disability.

It is widely believed that the risk of postoperative inflammatory complications depends largely on the level of immunity and age, as well as associated pathology and chronic intoxication of the patient (alcohol and drug addiction). According to our observations the level of immunity in the maxillofacial patients is not at a high level. Many diseases of the maxillofacial region are likely to disrupt the power function and, consequently, reduce the patient's immunity. Due to the environmental problems and changes in the living conditions the doctors often have to deal with immunologically weakened patients.



Fig. 1. Clinical view of infected wound of oral vestibule 3 days after its primary surgical debridement. Sutures fail, suppuration with tissues necrotizing are observed because of violation of the surgeon's recommendations by the patient (rejection of antibiotics, bad oral hygiene and alcohol abuse).

It should be noted that in recent years the increased contingent of elderly patients, as well as those after effects of stress, trauma and with concomitant diseases, is increased. Factors that may contribute to the development of postoperative infectious complications are: violation of aseptic conditions, elderly age, obesity, inadequate hemostasis, significant blood loss, the degree of tissue damage in the area of the surgical wound, use of electrosurgical cautery, violation of technique and the duration of the operation, use of drainage of postoperative wounds, and others.

All operations depending on the risk of postoperative infectious complications after surgical interventions in maxillofacial surgery can be divided into the following groups:

- **«Clean»** surgeries are an extraoral surgeries which do not penetrate into the oral cavity (plastic surgery of the eyelids, face and neck, as well as removal of tumors and tumor-like formations of the parotid and submandibular glands, etc.);
- **«Conditionally clean»** are the surgeries, which are performed by an extraoral approach, but there is a risk of penetration into the oral or nasal cavity, as well as operations after elimination of previously existing inflammation (osteosynthesis of the mandible, removing of second branchial cleft cysts and fistulas, etc.);
- **«Dirty»** or **«potentially infected»** (**«contaminated»**) are the surgeries which are performed by an intraoral approach (resection of teeth roots, dental implants, high-morotomy, removing of lesions in area of alveolar process and body of maxilla and mandible, surgical debridement of the wounds [Fig. 1] etc.);
- **«Purulent»** surgeries are the surgical intervention on the lancing of purulent periostitis, abscesses, phlegmons, sequestrectomies, etc.

Antibiotic prophylaxis is intended to reduce the likelihood of surgical wound contamination by the pathogens and prevent further microbial growth.

Preoperative antibiotic prophylaxis is only a supplement, not an alternative to good surgical technique of operation. If the infectious process was already running at the time of surgery, the administration of prophylactic antibiotics 3-4 hours after its performance is already ineffective.

Considering the specifics of work of the maxillofacial and oral surgeons, we would like to dwell on the microflora of the mouth. Species composition of oral microflora in healthy people is fairly constant. The number of microorganisms varies depending on the salivation, consistency and nature of the food, oral hygiene, the state of the tissues and organs of the oral cavity and the presence of systemic diseases. In the oral cavity a large number of different species of bacteria is contained, much greater than in other parts of the gastrointestinal tract. A significant number of contained types of microorganisms can also be explained by the fact that the bacteria enter into the oral cavity with air, water, food, i.e. they are so-called transit microorganisms, stay of which is limited.

The oral microflora is permanent, contains nearly 30 microbial species, it forms a stable and fairly complex ecosystem of the oral cavity. Thus, the mouth is a type of ecological system, which is closely related to the internal medium of the organism and its environment. An integral part of micro-ecosystem of the oral cavity is normal microflora that provides colonization resistance, which is seen as the primary target for any factor which directly or indirectly affects the non-specific resistance of this ecosystem. Permanent microflora of the human oral cavity is formed as a result of mutual adaptation of the organism and microbes. Adaptive and related biological changes lead to «balance» between a human body and the microbial flora, and between the components of its species of microorganisms. This «equilibrium» is of dynamic type.

Disorders of salivation, chewing and swallowing always lead to an increase in the number of microorganisms in the oral cavity. The same effect is observed in a variety of anomalies, defects and diseases that hinder leaching micro-organisms by saliva flow (cariou lesions, periodontal pockets, poorly manufactured non-removable dentures, admaxillary inflammatory processes, etc.).

The composition of the microbial flora of the oral cavity is not uniform. In different areas the various quantitative and qualitative composition of microorganisms are defined. The microflora of the oral cavity varies extremely and includes bacteria, actinomycetes, fungi, protozoa, spirochetes, rickettsia, viruses. It should be noted that some part microflora of oral cavity of adults are anaerobic species. There are obligate and facultative anaerobes. Obligate anaerobes are killed in the presence of free oxygen in the environment. Facultative anaerobes can persist and proliferate in oxygen or in oxygen-free environment. The facultative anaerobes are *E. coli*, staphylococcus, streptococcus and other bacteria. Obligate anaerobes can be divided into two groups: bacteria, spores forming (clostridium) and bacteria (non-clostridial) anaerobes. Among the bacteria which form spores, anaerobic pathogens clostridial infections are distinguished, i.e., gas gangrene. The non-clostridial anaerobes include: *Bacteroides*, *Fusobacteria*, *Veillonella*, *Peptococcus*, *Peptostreptococcus*, *Eubacteria*, etc.

In the mouth, the saliva affects microorganisms, mechanically washing out bacteria and by containing antimicrobial agents (lysozyme). But in the oral cavity, there are always areas easily colonized by microorganisms (gingival pockets, gaps between teeth, teeth eruption). The highest concentrations of microbial colonies in adults are formed in the interdental spaces, physiological gingival pockets (gingival sulcus), dental plaque, in the retromolar space, in the area of the tonsils and back of the tongue, especially in its posterior parts.

The composition of oral microflora includes microorganisms, some of which are forms of autochthonous flora, while others – allochthonous (inherent in other areas). Autochthonous flora consists of local microorganisms which are characteristic of the oral cavity. Among the autochthonous microorganisms the resident (obligate) and transient species are distinguished. Allochthonous microflora of the mouth is represented by microbes inherent in other areas (it is composed of species that normally live in the intestines, nose and throat and other parts of the human body).

Microflora of the mouth also can be divided into two groups: a constant (physiological or normal) microflora, i.e. set of different species of microorganisms, which is characteristic of a healthy person; random (transient) microflora is a saprophytic and pathogenic microorganisms which enter the oral cavity from the outside (after surgery, etc.).

The qualitative composition of the resident microflora of the mouth of every healthy person varies in a limited extent. It is known that among the bacterial flora of the oropharynx the streptococci dominate. The majority of Gram-positive cocci oral represented a heterogeneous group of low virulence viridans *Streptococci*, which are actively involved in the processes

that lead to lesions of dental hard and periodontal tissues. This group includes *Streptococcus mutans*, *S. sanguis*, *S. mitis*, *S. salivarius*. Often they are found jointly with *Fusobacteria* and *Spirochetes* during caries, pulpitis, periodontitis, abscesses of the maxillofacial region. The second group of Gram-positive cocci are peptococci.

Less aerated areas are colonized by anaerobes – *Actinomycetes*, *Bacteroides*, *Fusobacteria* *Veillonella*. The genus *Fusobacterium* is bacteroids with autochthonous flora of the mouth. *Fusobacteria* live in gingival pockets with *Spirochetes* association. Gram-negative anaerobic cocci are represented by genus *Veillonella* and are permanent inhabitants of the oral cavity of man. *Veillonella* concentration in saliva is approximately the same as that of *Streptococci viridans*. Most often there are two types of *Bacteroides* – *V. melaninogenicus*, *B. gingivalis*. *B. melaninogenicus* is a regular inhabitant of the gingiva in adults and has a great pathogenetic importance in the development of periodontal diseases.

In oral cavity, there are the *Spirochaetes* genera of *Lep-tospira*, *Borrelia* and *Treponemas*, *Mycoplasmas* (*M. orale*, *M. salivarium*), *Candida* species and a variety of Protozoa (*Entamoeba buccalis* and *E. dentalis*, *Trichomonas buccalis*). In the oral cavity, there are also genera *Actinomyces* and *Bifidobacterium*. *Actinomycetes* are on the oral mucosa, may participate in the formation of dental plaque and caries and periodontal diseases. Very often in these pathological processes *A. viscosus* and *A. israelii* are found. *A. viscosus* is involved in the formation of subgingival calculus.

In the oral cavity, bacteria genus *Corynebacterium* is found. A characteristic feature of *Corynebacterium* is its ability to reduce the redox potential, thereby creating conditions for the growth of anaerobes. In case of periodontal diseases they are found in association with *fusobacteria* and *spirochetes*. Thus, the composition of microbial species, which are in oral cavity is complex one.

Relative ease of ingress of bacteria from the oral mucosa or other local purulent lesions in the blood stream determines the relatively high incidence of oral sepsis. The presence in the oral cavity of poorly cleaned cavities, gingival pockets and other areas contributes to the persistence of pathogenic microorganisms and causes the formation of a sufficiently high rate of chronic infection foci (staphylococcal, streptococcal, etc.) with following allergization of the body.

The main measures for reducing the number of postoperative inflammatory complications are as follows:

- Before carrying out operations it is necessary to sanitize the oral and nasal cavities;
- Special attention should be paid to the reduction of both exogenous and endogenous infections of surgical wounds during the operation, i.e. performing aseptic;
- During an operation it is necessary to take care of the tissues, which reduces the probability of formation of zones of ischemia, necrobiosis and necrosis in the surgical wound;
- Should be a rational and targeted preoperative antimicrobial prophylaxis.

Taking account of the leading role of microorganisms in causing inflammatory processes in maxillofacial area, the prescription of antibacterial therapy no one question. Antibiotic therapy is carried out both during the treatment of patients with already arisen abscesses and phlegmons, and for the prevention of inflammatory complications after a «clean», «conditionally clean» and «contaminated» («potentially infected») surgical interventions. Routes of administration of antimicrobial drugs, their dosage and duration of prophylactic antibiotic therapy depends on the reactivity of the patient, the volume of the surgery, the presence of concomitant diseases, etc.

Rational prescribing of antibiotic prophylaxis, in terms of reducing the risk of postoperative inflammatory complications during the surgery, no one question. The choice of antimicrobial drug for the prevention of postoperative infectious

complications is difficult because in the occurrence and development of these processes, usually not one microbial pathogen, but a few – microbial associations are involved (from 3 to 6). When planning prophylactic antibiotics in outpatient it is advisable to focus on the purpose of oral antibiotics with high bioavailability, long half-life and minimal side effects of their actions. In carrying out preventive measures for patients in a hospital environment it is advisable to choose an antibiotic for sequential therapy, i.e. antibacterial drug, which has forms for the parenteral and oral routes of administration.

Requirements to the antibiotic that is used for the treatment and prevention of inflammatory complications are:

- The antibiotic should be active against microorganisms groups, which are most often found in chronic odontogenic inflammatory foci;
- Spectrum of antibiotic activity must comply with possible representatives of microflora characteristic of the treated area;
- The drug must have the least ability to induce resistance of microorganisms;
- Antibiotic should well penetrate into the tissues in which surgery is performed (in operations for opening abscesses and abscesses - in soft tissue, jaw operations – the bone);
- The level of the antibiotic in abnormal foci must reach minimum inhibitory concentration (MIC) and maintain at that level for the required time;
- Antibiotic should provide minimal side effects and does not adversely interact with other medications that may be concurrently used (anesthetics, analgesics, etc.).

It was found that the activity of antibiotics against pathogenic microorganism is not constant; it decreases with time due to formation of antibiotic resistance - microbial resistance to antibacterial drugs.

An important requirement for adequate prophylactic antibiotic therapy is the ratio of the value and effectiveness of the antimicrobial agent. For the treatment and prevention of inflammatory complications in maxillofacial region the paren-

teral route of administration of antibiotics is the most commonly used. At cost indicators, the frequency of side effects and convenience of use oral dosage forms possess significant advantage. In the last decade, we have increasingly observed high efficiency of «stepped» antibiotic therapy (synonyms: sequential, step-down, switch therapy), which occupies an increasingly strong position in the practice of medicine. Under step antibiotic therapy the gradual transition from parenteral to oral route of administration for the improvement of the patient's condition is implied. The main criterion for the transition to the reception of the drug inside is the normalization of body temperature or its significant reduction. The transition to the oral route of administration has a number of advantages: reducing the load on the medical staff, material savings (spent on disposable syringes, intravenous systems), the disappearance of the risk of postinfective complications development (inflammatory infiltrates, phlebitis, etc.) and others. However, the antibiotic, which can be used for sequential therapy must meet certain requirements. The main one is the maximum range of the proximity antibacterial preparations for parenteral or oral route, as well as their high bioavailability (in the serum virtually the same concentration of the drug, regardless of its route of administration, to be created).

With prophylactic aim the antibiotics should be used in the following surgical interventions: removal of impacted teeth and dystopic, the apices of the teeth roots resection, cystectomy, dental implant, removal of tumors and tumor-like formations, uncomplicated fractures without displacement of jaw fragments, plastic and reconstructive surgeries and other diseases. Assuming division of operations in terms of surgical wound purity, it should be noted that for prophylactic antibiotics for «clean», «relatively clean» and «contaminated» («potentially infected») operations are indicated. The appointment of antibiotics for «purulent» operations (abscess, phlegmons, etc.) is indicated for the prevention of secondary complications that may arise as a result of the progression of already developed chronic inflammatory diseases.

REFERENCES

1. Тимофеев А.А. Руководство по челюстно-лицевой хирургии и хирургической стоматологии. – 5-е изд., перераб. и доп. – Киев: ООО «Червона Рута Турс», 2012. – 1048 с.
2. Тимофеев А.А. Челюстно-лицевой хирургия. – Киев: «Медицина», 2015. – 800 с.

Профілактика запальних ускладнень

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Резюме. Проведення профілактичної антибіотикотерапії у хворих після проведення оперативних втручань в хірургічній стоматології і щелепно-лицевій хірургії сприяє зниженню частоти розвитку післяопераційних запальних ускладнень. Розглянуті загальні питання антибіотикопрофілактики, мікрофлори порожнини рота. Дані рекомендації за методикою проведення профілактичної антибіотикотерапії в хірургічній стоматології і щелепно-лицевій хірургії.

Ключові слова: антибіотики, профілактика, мікрофлора, ступінчаста антибактеріальна терапія, гнійно-запальні ускладнення, хірургічна стоматологія, щелепно-лицева хірургія.

Профилактика воспалительных осложнений

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Резюме. Проведение профилактической антибиотикотерапии у больных после проведения оперативных вмешательств в хирургической стоматологии и челюстно-лицевой хирургии способствует снижению частоты развития послеоперационных воспалительных осложнений. Рассмотрены общие вопросы антибиотикопрофилактики, микрофлоры полости рта. Даны рекомендации по методике проведения профилактической антибиотикотерапии в хирургической стоматологии и челюстно-лицевой хирургии.

Ключевые слова: антибиотики, профилактика, микрофлора, ступенчатая антибактериальная терапия, гнойно-воспалительные осложнения, хирургическая стоматология, челюстно-лицевая хирургия.

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