Changes to Antibiotic Prophylaxis Guidelines

Changes to Antibiotic Prophylaxis Guidelines issued by Wessex Cardiologists to Prevent Infective Endocarditis in at Risk Patients Undergoing Dental Procedures

Letter to Dentist on changes to Antibiotic Guidelines

Letter for Referral from Cardiologist

Letter to Patient

The LMC view this recommendation as a pragmatic response to the current somewhat ambiguous NICE guidance which appears at odds with practice in other countries around the world.

There was an interesting letter in the BJGP (Br J Gen Pract 2016; 66 [650]: 460-461) which gives credence to the above guidelines:

‘You’d be forgiven for missing it, because it was announced without fanfare, but the National Institute for Health and Care Excellence (NICE) has added the word ‘routinely’ to Recommendation 1.1.3: ‘Antibiotic prophylaxis against infective endocarditis is not recommended routinely for people undergoing dental procedures’ [authors’ emphasis].

This change occurred after a patient with a replacement aortic valve died from infective endocarditis (IE) developing after unprotected descaling, and followed approaches to NICE by the patient’s widow and her MP. Their case included: evidence that antibiotic prophylaxis is effective in people at high risk of IE having high-risk dental procedures (Box 1); 3 the observation that the incidence of IE in the UK has accelerated above the global background rise since the original 2008 NICE guidance;4 and a change in the law on consent.

Box 1.

Summary of guidance

1. Patients at high risk: replacement heart valves or prior endocarditis.
2. Patients at moderate risk: native valve disease.
3. High-risk dental procedure: extraction, deep descaling.
4. Antibiotic prophylaxis: indicated for people at high risk having high-risk dental procedures. Record details of consent process in the dental notes. Use amoxicillin 3 g or clindamycin 600 mg orally 1 hour before.
5. Other advice: dental surveillance 6-monthly (high-risk patients) or annually (medium-risk patients); avoid tattoos and intravenous drug use.

Warning: consider infective endocarditis with unresolving fever or night sweats, especially with
systemic symptoms. Consider blood cultures before starting an antibiotic course.

It is now necessary for dentists to explain to their patients the differences between NICE and other guidelines if it is likely that they would have a special interest, for example, patients with replacement heart valves or prior IE. Their GP or cardiologist may consider advising the patient and their dentist on the level of risk by letter. The dentist should then allow the patient to make up their own mind whether or not to have antibiotic prophylaxis. The General Medical or Dental Councils’ standards and the advice of the medical or dental defence organisations highlight the need for this discussion (and the patient’s decision) to be recorded in the clinical records.

Prophylaxis should be with amoxicillin 3 g by mouth 1 hour before the procedure or, for patients with penicillin hypersensitivity, using clindamycin 600 mg. Other guidance is given in Box 1. It is also important to educate patients at risk in recognising the possibility of IE, typically if there are unresolving night sweats, especially with constitutional symptoms like weight loss. The British Heart Foundation produces warning cards that can be given to patients:

https://www.bhf.org.uk/publications/heart-conditions/m26a-endocarditis-card.

The subtle change makes NICE guidance less dogmatic and allows clinicians to use their clinical judgement, follow well-accepted international guidelines, and provide the care their patients want.

The local guidance seems to put the emphasis on dentists issuing the antibiotics and we are assured they are able to prescribe both amoxicillin and clindamycin. That said, we would take a pragmatic approach to issuing antibiotics if requested as its in everyone's interest for our patient not to get infective endocarditis.