



MASTEROPPGAVE

**Paediatric dentistry under
general anaesthesia**

From a patient perspective

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Abstract

Introduction: The importance of good oral health in children is well documented. Extensive caries in young children has an impact on both oral and general health, including quality of life. It is important to offer DGA for patients where other options are not sufficient. Preventive measures can in many cases be done to reduce the number of DGA needed, and behaviour shaping techniques for all children will in the long run be cost effective. In Tromsø DGA is performed by two paedodontists.

Objective: Investigate patient experiences with dental treatment under GA in Tromsø, with emphasis on preventive measures previous to DGA, information received and patient follow-up. If necessary promote suggestions for improvement.

Method and materials: Telephone interviews with the parents of ten children that had received DGA at UNN Tromsø.

Conclusion: Most parents were content with overall DGA experience and found the waiting time from referral to treatment acceptable. In most cases, other measures had been tried before DGA. Some improvements could be done regarding parent information.

Introduction

In Troms county council, dental general anaesthesia (DGA) is performed at the University hospital of Northern Norway in Harstad and Tromsø (UNN Harstad and UNN Tromsø). Most of these have been performed at UNN Tromsø. Between 2005 and 2010 there were on average 30 - 40 paediatric DGA performed every year at UNN Tromsø. In 2009, DMFT for Troms county council was 0.6 for five-year-olds, 1.4 for twelve-year-olds and 5.5 for eighteen-year-olds (1). This is above the Norwegian average. The number of referrals to the Department of Specialist Paediatric Dentistry at the Public Dental Service Competence Centre of Northern Norway (in the text referred to as TkNN) is increasing (2). The department at TkNN was established in 2006. At UNN Tromsø, paediatric DGA was performed by the two paedodontists working at TkNN.

General anaesthesia (GA) is defined as: “A medically controlled state of unconsciousness accompanied by a loss of protective reflexes, including the inability to maintain a patent airway independently and respond purposefully to physical stimulation or verbal command” (3). The use of DGA is restricted because GA involves a small risk of complications, although it is quite safe when performed in a hospital. Additionally, it involves an increased use of resources. DGA is most commonly used for patients with dental fear and anxiety (DFA) or behaviour management problems (BMP), in addition to an extensive treatment need. It is often used as a last resort for patients who cannot be treated in any other way, e.g. children with mental and/or physical disabilities or other reasons for low coping ability.

For patient with DFA and/or BMP, there is a potential of reducing the need for DGA with the use of behaviour shaping techniques/ behaviour shaping therapy (later referred to as behaviour shaping). This is done stepwise, by first explaining and then showing the child what will happen, before exposing them to the procedure. Behaviour shaping is most effective if done before an extensive treatment need occurs. Therefore, all children should receive behaviour shaping appropriate for their age and need of examination/treatment. In the long run, behaviour shaping of all children will be cost effective (4).

In patients who are unable to cope with dental treatment despite of behaviour shaping, conscious sedation is an option. Conscious sedation is defined as: “A medically controlled state of depressed consciousness that allows protective reflexes to be maintained, retains the patient’s ability to maintain a patent airway independent and continuously, and permits appropriate response by the

patient to physical stimulation or verbal command, e.g., “open your mouth” (3). This is indicated in patients with high DFA and a need for reduction of fear induced pain, and in emergency situations (5). The dental indications for use of conscious sedation in children written by Norwegian Medicines Agency (6) state that the use of conscious sedation should be limited to children with a moderate treatment need. This is defined as no more than three treatment sessions. The restorative treatment should be uncomplicated (up to 3 surfaces per tooth), in a limited number of teeth (up to six teeth), and need for emergency treatment like uncomplicated extractions and trauma. Conscious sedation performed by dentists can be administered orally, rectally, and/or by inhalation.

The importance of good oral health in children is well documented. Extensive caries in young children has an impact on both oral and general health, including quality of life (7). Dental disease affects children’s physically, psychically, behaviourally and socially. After DGA, studies have shown that children with serious dental disease have an improvement in quality of life. Those with the greatest need showed the greatest improvement (7, 8).

Objective: To investigate the child patient parents’ experiences with dental treatment under general anaesthesia in Tromsø, with emphasis on received pre- and post-information, pre-operative care (preventive measures previous to DGA) and post-operative follow-up.

Material and methods

For this study, ten subjects were selected from the list of children that had undergone DGA at UNN Tromsø. The subjects were selected at two different occasions, five each time, six months apart. At both occasions these were the last five patients treated, whose parents agreed to participate. In the second batch, one patient was excluded on the basis of need for extensive prosthodontics, and two patients did not want to participate. The subjects consisted of 5 girls and 5 boys in the age range of 4 to 11 years. The material contained patients treated by both dentists performing paediatric DGA at UNN Tromsø.

To have some background for our interviews, the authors participated at two DGA's at UNN Tromsø, including pre- and postoperative information with the patients and their parents. We also talked to the personnel at the children's day care unit at UNN Tromsø.

The mentor responsible for the patient selections telephoned the parents of each child. They were asked if they would participate in the study, involving telephone interviews, and if they allowed access to the dental records. This oral consent was followed by a letter with information about the study. A telephone interview was made with one of the parents of each child, nine mothers and one father. At that interview, all the parents agreed to a second telephone interview if necessary. A premade form including 20 questions according to tables 1 and 2 was filled in by the interviewers (the authors). The parent was put on speaker phone, in order for both interviewers to be able to fill in the form. Afterwards the two forms were compared and merged to insure that all relevant information was included. In addition, the parents were also asked to answer the following five essay questions:

1. What do you think of as positive and negative aspects of receiving dental treatment under general anaesthesia?
2. What information did you receive prior to the DGA?
3. Did you feel there was any lack of information?
4. Based on your experience, do you have any suggestions for changes?
5. Do you think your child will need DGA in the future?

After assessing the information from the first interview, we decided some explanatory questions were necessary. A total of two interviews were made. The first interview was made with all ten participants, and the second with nine participants. We were not able to reach one of the parents for the second interview. The information from both interviews are listed together.

The dental records were studied with regards to measures done previous to DGA, time from referral to DGA, reason for referral, patient's age and treatment received at DGA.

As this was considered a qualitative study on a small non-random sample no statistical analyses has been performed.

Results

Results from the interviews

The results of the 20 standardized questions answered by the parents are presented in tables 1 and 2. The study revealed that six of the children had DFA, and five of these had had previous negative experience. Four of the children had parents or close family with DFA. One child had DFA, though, according to the parent, the child has no negative experience with dental treatment. The parent thought the DFA might have derived from an arm fracture and a change of dentist shortly after.

Two of the parents interviewed, said their child had behaviour shaping at their regular dental clinic. Six children had tried conscious sedation prior to DGA. Three children did not swallow all the sedative liquid, and desired dose was not achieved. Two of these had tried conscious sedation two times, both with adverse effect. Three children accepted the liquid, but with minor or adverse effect. One child had been given nitrous oxide-oxygen sedation (at TkNN).

After referral, but before DGA, eight children had received behaviour shaping at TkNN. Five had positive effect, but two children did not cooperate for treatment despite behaviour shaping.

Eight parents were content with information received from TkNN, and seven were content with information received from UNN Tromsø. Nine parents were content with the overall information received regarding their child's DGA. Eight parents received written information and six of these also received information orally. All parents reported to have received information, either orally, written or both. Seven parents felt well cared for during the whole process. Two of the ten did not feel they got enough information while waiting for, and during treatment, but both felt well cared for after the procedure.

Table 1. Results of the standardized questions

Table 1				
	Number of patients			
	Yes	No	Don` t know	Not relevant
Patient has dental fear/ anxiety	6	2	2	
Parents/family have dental fear/anxiety	4	6		
Previous negative experience with dental treatment	6	3	1	
Behaviour shaping at regular dental clinic	2	6	1	1
Conscious sedation	6	3		1
Positive effect of conscious sedation	0	5	1	4
Nitrous oxide-oxygen sedation	1	8		1
Positive effect of nitrous oxide-oxygen sedation	1			9
Behaviour shaping at TkNN	8	1		1
Positive effect of behaviour shaping at TkNN	5	2		2
Content with information received from home dentist regarding referral	3	3		4
Content with information received from TkNN	8	2		
Content with information received from UNN Tromsø	7	2	1	
Content with total information received	9	1		
Received written information	8	1	1	
Received oral information	8	2		
Well cared for	7	2	1	
Behaviour shaping / Follow-up at regular dental clinic after DGA	7	1		2
Behaviour shaping / Follow-up at TkNN after DGA	6	4		

Table 2. Waiting time from referral to DGA as reported by the parents.

Table 2		
Waiting time	According to parent	According to dental record
Less than 3 months	2	4
3-6 months	4	3
6 - 12 months	2	2
12 - 18 months	1	1
Don't know	1	

Results from dental records

Table 3 and 4 lists information found in the dental records.

According to our interpretation of the dental records, seven of the children had received behaviour shaping, while 6 children had experienced conscious sedation. In all these cases, the sedative was given in a liquid solution. There were little or no information in the dental record regarding the dentist's evaluation of the sedative effect. Six children had follow-up/ behaviour shaping at TkNN after DGA. Seven had this at their regular dental clinic. One had not had any follow-up.

Table 3. Reason for referral according to the dental record.

TABLE 3	
	Reasons for referral
Patient 1	DFA and caries requiring treatment
Patient 2	DFA and caries requiring treatment
Patient 3	Severe hypomineralization of all permanent first molars (MIH)
Patient 4	Large treatment need in young/immature patient
Patient 5	Mesiodens
Patient 6	Large treatment need in young/immature patient
Patient 7	BMP and large treatment need
Patient 8	ADHD/BMP/DFA and large treatment need
Patient 9	Mental disability
Patient 10	DFA/BMP and caries requiring treatment

Table 4. Treatment done under DGA according to the dental journal.

Table 4				
	Age at treatment (years)	Extractions	Fillings	Other
Patient 1	10	2 **	1 temporary filling**	1 fissure sealant
Patient 2	9	1 * 2 **	1 **	Examination 4 fissure sealants
Patient 3	10	4 **	2 *	
Patient 4	5	8 *	1 *	Examination 3 fissure sealants
Patient 5	6	3 *		Removed mesiodens
Patient 6	4	4 *	5 *	
Patient 7	11	5 *	8 **	5 fissure sealants
Patient 8	9	3 *		Examination 4 apical radiographs 4 fissure sealants
Patient 9	5			Examination Professional cleaning Fluoride application
Patient 10	5	2 *		

Primary tooth: *

Permanent tooth: **

Results from the essay- and explanatory questions

1a. Positive aspects of DGA:

- DGA allows necessary treatment to be done, and all treatment could be done in one session
- Prevents progression and removes pain
- Only solution - because of DFA, extensive treatment need for a small child or mental disability
- Patient is lying still during treatment. Enables more thorough examination
- Patient can be helped, despite trouble with keeping their mouth open
- Patients may be less anxious before treatment, and perhaps less risk of DFA in the future
- Patient does not need to be aware of all treatment, no pain and no memory of the procedure

1b. Negative aspects of DGA:

- GA involves a risk of complications, from not waking up from GA to nausea and discomfort after treatment
- Difficult to administer GA to anxious patient
- The child may look at GA as a simple solution, and may choose the “easy way out” on later occasions as well

2. Information received:

- Only a few of the parents could remember having received written information from TkNN. These thought it was adequate.
- Most parents had received written information from UNN Tromsø, and were content with this, although one parent thought it was inadequate
- Most parents also received oral information from personnel at TkNN/UNN Tromsø

3. Lacking information:

- Most parents were content with the information received, and felt they could ask if something was unclear
- One parent felt they did not get enough information on possible complications, although they asked directly about this
- Two parents felt they did not get enough information on what would happen after treatment, and what precautions were needed
- One parent complained that the treatment had taken more time than informed
- One parent said they had not been told where the treatment would be performed
- One parent said they had not been told that they would have to meet on two separate days, and therefore the child was fasting already at the general examination prior to GA

4. Parent suggestions for changes:

- Three parents thought the waiting time before treatment ought to have been shorter. These were not necessarily those who waited the longest.
- Two parents had wished for more information about what would happen before and after treatment, one parent especially regarding when and what the child could eat
- One parent thought their general dentist ought to have had a lower threshold for referral – patient experienced dental pain previous to DGA
- One parent thought their general dentist ought to have had a higher threshold for referral, that the dentist was too impatient
- One parent commented that the child had not been offered sedatives before DGA
- One parent commented that their child had received sedatives before DGA. The parent thought this was unnecessary
- One parent thought there were too many follow-ups, especially because of great travelling distance
- One parent had prepared their child for treatment before the first visit, although this was just a check-up. The parent suggested the appointment card should state what is scheduled

5. Parents thoughts on future need of DGA:

- Many of the parents were unsure whether their child would need DGA in the future. Most of them did not think so. Only one parent was sure that the child would not need this under normal circumstances
- One parent thought the child would need DGA in the event of reparative dentistry because of mental disability
- Four of the parents mentioned that the probability of their child needing DGA would decrease with increasing age and maturity
- One parent mentioned that their child was well prepared after behaviour shaping

Discussion

Most of the parents were over all content with the information received prior to, during and after DGA, and felt well cared for in total. On a general basis, it seemed the waiting time was acceptable, and that children with great need were prioritized. Most of the patients had tried other measures prior to DGA.

Previous painful experiences and perceived lack of control during dental treatment are commonly mentioned causes of DFA/BMP (9, 10). This tendency could also be seen in our subjects. It was previously believed that young children could not register pain in the same way as adults because of immature CNS. However, recent studies have proven this wrong and small children are at least as pain sensitive as adults (11). Unfortunately, this earlier misconception has led to children being treated without local anaesthesia. A change in knowledge regarding children and pain ought to reduce the prevalence of DFA/BMP among children. According to a review, this is however difficult to assess, and there has not been done any studies with large enough samples to draw any conclusions (12). Our study showed a correlation between DFA and previous negative experience, but we could not see correspondence between DFA/BMP among children and their parents, although this is a well-known association (13).

Few of the parents reported their child having received behaviour shaping at their regular dental clinic, although, from our interpretation of the dental record, most of them had. One child had a mental disability, and had done all dental examinations and treatment in relation to other treatments requiring GA. The plan was to start behaviour shaping at the regular dental clinic in near future. All children, regardless of treatment need, should have behaviour shaping to learn the procedures to be performed (14). No behaviour shaping gives the child less feeling of control and can predispose to DFA/BMP (9, 10).

All the parents reported only minor or adverse effects from the conscious sedation; the child not liking to lose control, being uncooperative and tense. Only three of the six dentists performing conscious sedation mentioned the effect in the record. Especially in cases where conscious sedation is unsuccessful, the dentist should state this and explain the effect. Only in one case the treatment planned to be performed under conscious sedation was completed, and this was with the child held down. One reason for unsuccessful conscious sedation could be insufficient dosage. Two of the six

patients given conscious sedation did not fit into the recommendations from the Norwegian Medicines Agency (6). The recommendations state that children with a greater treatment need should be offered GA because of the larger physical and psychological strain. Children are a complex, heterogeneous group, and the treatment suited for some is not necessarily good for others. However, according to a cluster analysis performed by Arnrup et. al. (15), uncooperative children can be divided into four subcategories: Non fearful extravert outgoing, fearful extravert outgoing, fearful inhibited and externalizing impulsive. For conscious sedation it is the fearful patients who are best suited. Without having met the children, it would be hard to classify them in this manner, but possibly, this sedation was not suited for them.

Only one child had had nitrous oxide-oxygen sedation (at TkNN). The parent thought the effect was positive, even though the planned treatment was not completed. The parent informed that this worked better than orally administered conscious sedation, and would have liked to try it again had they not received DGA. The dentist requires additional training and equipment, and nitrous oxide-oxygen sedation is therefore not as common as other methods of conscious sedation. In 2010 there were only five clinics performing nitrous oxide-oxygen sedation in Troms County Council, including TkNN (16). Studies indicate that nitrous oxide-oxygen sedations might prevent further development of DFA (17).

All children are routinely offered behaviour shaping at TkNN previous to DGA. One child had not received behaviour shaping because the parent did not want it. The child had a great treatment need (extraction of four molars with severe hypomineralization, MIH), and had no DFA. One child had a mental disability, and received all dental examination and treatment under GA. Two children did not cooperate for treatment despite behaviour shaping.

Most parents were content with information received from UNN Tromsø and TkNN. The complaints were about lack of information on possible complications, and too little information afterwards, regarding which treatment had been performed. One of the complaining parents did not receive a letter in the mail after treatment, as promised. Only one parent was not content with over all information. The child, whose parent was not content, was only four years old at time of treatment. The parent felt they did not get enough information on possible complications of the treatment, and had wished for more updates during the procedure. The estimated treatment time was

exceeded, which the parent found very troubling. They were not content with information received either from their regular dentist, TkNN or UNN Tromsø.

Most of the parents felt well cared for in total, but two of them did not feel adequately informed during the DGA. In many cases it is difficult to know before DGA what treatment is needed and therefore impossible to give a precise time estimate. A few of the parents wanted/ requested updates during the procedure; however this is not feasible because of hygiene requirements and time pressure. The parents should be informed of this prior to treatment.

Parents' reports on waiting time were on average slightly overestimated. Most children were appointed to DGA relatively soon after referral, although one child waited over a year, and experienced pain in the meantime. This was very unfortunate, and there seemed to have been a glitch in the routines in this particular case. On a general basis, waiting time was acceptable, and children with urgent need were prioritized. The statistics of DGA at UNN Tromsø shows that in 2010, the average waiting time for DGA for children was three and a half months (18). There has been a decrease in waiting times in the last years.

One child had not had any follow-up/ behaviour shaping, neither at TkNN nor at their home clinic. They were offered a follow-up at TkNN, but were not able to come at the scheduled time, and had not been offered a new appointment. They were waiting for an appointment for routine examination at their regular dental clinic. Good follow-up after DGA is important and a recent study indicates that irregular attendance and oral pain and infection predispose to repeated DGA (19). This points to the importance of a good follow-up and further behaviour shaping before new caries lesions can develop and DFA can arise/worsen. Our study had a too small timeframe to catch any new caries development. The purpose of the specialist services is to perform treatment that the regular dentist cannot do. To relieve the paediatric dentist specialist service, it is important to have the child enrolled in the regular dental health services as soon as possible (20). Good cooperation with the child's regular dental clinic is therefore important after DGA.

Most parents were worried about the risks involved in GA; however they all agreed that the positive aspects outweighed the negative. The listed suggestions for changes were partly contradictory. It is

hard to give a standardized offer that pleases all. Therefore a communication with the patients and their parents is important.

The parents' thoughts on their child's further situation were predominantly positive; most of them thought their child would not need DGA in the future. The parent of the child with mental disability thought their child would require DGA if restorative dentistry was ever needed. Two parents requested more behavioural shaping at their regular dental clinic than they were offered.

The parents all reported receiving information, but were uncertain about the origin, and to some degree the content. Some parents reported not having had information that we know is to be found in the brochures they reported having received. The personnel at the paediatric surgical day care unit commented on parents not reading the brochures thoroughly as being a common problem. They have tried to change the brochure to highlight the essence, but still experienced the same problems, e.g. patients meeting fasting for the general examination and having no place to stay the night (Appendix 2). A contributory factor to parents not remembering all information received could be that some time passed between the DGA and interviews. The dental paediatric patients receive information from many sources on several occasions (Appendix 1 - 4). In total they are supposed to receive four different informative brochures and prints, some by mail and other handed out directly; in addition to consent forms and health forms they are required to fill in. One consequence of receiving too much paper could be that important information is not read properly.

A weakness with the present study was the small sample, and we could not make any relevant statistics from the results. The information was gained through interviews and was subjective. Because of the short time frame, we could not assess the possible need to repeat DGA. Our sample of subjects varied and included patients with a variety of problems, although we could not know whether it was representative of all paediatric DGA's performed at UNN Tromsø. It contained five boys and five girls, and both dentists performing paediatric DGA at UNN Tromsø were represented. However, we only talked to one father. One other problem was that some time passed between DGA and interviews. This probably contributed to parents not remembering all information received.

Conclusion

The parents interviewed were mostly content with their DGA-experience, including information received and patient follow-up. However some improvement could be needed in written information handed out to the patients. One idea could be to try to summarize the information into one hand-out. Important information should be given first, and could be emphasized by bold letters and colours, in addition to the dentist repeating it orally.

In most cases, preventive measures had been tried before DGA with varying effect. However, in some of the cases, preventive measures were irrelevant, e.g. in event of dental anomalies and mental or physical disabilities. Most of the parents did not think further DGA would be needed.



ROMSSA fylkkásuohkan
TROMS fylkeskommune



Offentlighetlovens § 5a
Unntak for opplysninger undergitt
lovbestemt taushetsplikt

Godkjenning for behandling i narkose

Vi skal ha tannbehandling på din sønn/datter..... i
narkose

.....
Etter avtale med pasient og/eller foresatte, har vi fått tillatelse om
å gjøre den best mulig under disse omstendigheter. Vi har en
diagnose, men diagnosen kan endre seg under behandlingen.
Og vi må foreta noen valg, disse gjøres etter beste skjønn for
pasienten. Informert om dette muntlig.

Jeg/vi godkjenner denne erklæring;

Signatur.....
.....

Med vennlig hilsen

Besøksadresse
Hansine Hansensv. 86
Postadresse
Pb. 2406, 9271 Tromsø

Telefon
77 78 90 00
Epost mottak
tknn@tromsfylke.no

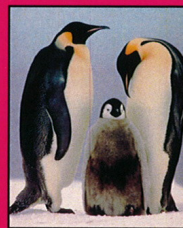
Telefaks
77 69 01 14

Bankgiro
4750 15 98360
Internettadresse
www.tromsfylke.no

Org.nr.
979 700 946



UNN -
verdens nordligste
universitetssykehus



INNHOLD

Om Dagenheten	side 2
Før dere kommer	side 3
Faste, reise, overnatting.....	side 4
På dagenheten	side 5
Sedering/likegladmedisin.....	side 6

Utgitt av
Barneavdelingen
UNN
oktober 2002

Layout og trykk:
Trykkeriet – UNN-Forsyning

Revidert sept. 2010

OM DAGENHETEN DRAGEN

Dagenheten Dragen er en del av Barneavdelingen, som er i 5. etasje – fløy B.

Gå inn på Barneavd. – sengepost. Vi holder til på første rom ved siden av venterommet. Døra er skiltet med Dagenheten Dragen.

Her gjøres ulike undersøkelser og behandling på barn som ikke trenger innleggelse. Det betyr at barn og pårørende møter til et ønsket klokkeslett, og reiser hjem samme dag.

Her jobber det to sykepleiere, samt at barneleger fra Barneavdelingen er tilknyttet.

Alt etter hva barnet er innkalt for, vil nødvendig tilleggsinformasjon være vedlagt denne brosjyren.

Skulle det være noe som savnes angående informasjon før dere kommer, ønsker vi tilbakemelding på dette.

FØR DERE KOMMER

For å forberede dere på hva som skal skje, må denne brosjyren og evt. vedlegg leses sammen med barnet

MEDISINER

Dersom barnet bruker faste, daglige medisiner, tas disse som vanlig om morgenen. Skal barnet til en undersøkelse som krever sedering (se side 6), og faste er nødvendig, kan medisinerne likevel tas med et halvt glass vann. Ta med medisinerne til sykehuset.

ETT BARN, EN FORESATT

På grunn av plasshensyn må vi dessverre oppfordre dere til at kun en pårørende følger barnet til avdelingen. Dersom flere følger barnet, må dere regne med å bytte på å være sammen med barnet.

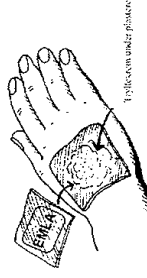
BEDØVELSESKREM

Dersom du skal ta blodprøve eller få venflon (et liteplastrør i en blodåre) får du bedøvelseskrem. Dette gjør vi for å minske ubehaget. Hvis dere har fått EMLA tilsendt, skal det settes på 1 time før dere kommer hit. Kremen settes over synlig blodåre på begge hender.

SYKDOM FØR DAGOPPHOLDET/ UNDERSØKELSEN

Hvis barnet er forkjølet, hoster eller har feber skal dere ta kontakt med oss så tidlig som mulig. Dette fordi dagoppholdet kanskje må utsettes, og da kan vi bruke den tiden imens til å ta inn et annet barn.

Har barnet i løpet av de 2-3 siste ukene før dagoppholdet vært utsatt for smittsomme sykdommer, eksempelvis vannkopper/meslinger, så ta kontakt med oss i god tid.



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FASTE FØR NARKOSE

- Barnet skal ikke spise etter kl. 24 dagen før narkosen.
- Kan drikke vann, saft, brus, juice uten fruktkjøtt inntil 2 timer før narkosen.
- Spedbarn som ammer kan amme inntil 4 timer før narkosen.
- Morsmelkerstatning kan gis 6 timer før narkosen.

VIKTIG! LES DETTE

OVERNATTING FØR ELLER ETTER DAGOPPHOLDET.

Skulle det være nødvendig med overnatting i forbindelse med dagopphold (ene), **må dere** bestille plass via pasienthotellet på UNN, tlf. 77 75 51 00. Dere må legge ut for oppholdet, og få refundert fra Helseforetakenes senter for pasientreiser ANS. Pasientreiser tlf. 05515 i ettertid. Dere må dekke en egenandel av dette beløpet.

NBI! Ved bestilling av plass ved pasienthotellet må det opplyses om pasienten har spesielle behov som f. eks.: Rullestol, spesialkost, spesielt utstyr etc.

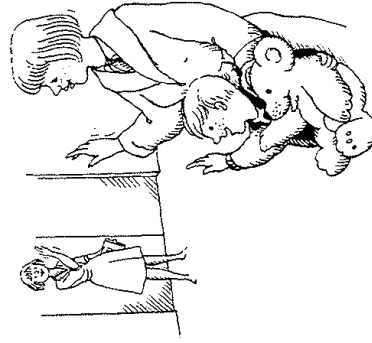
REISE TIL OG FRA DAGOPPHOLD

TRANSPORT

Reise til og fra sykehuset skal om mulig foregå med rutegående transport, eller med egen bil. Flyreise bestilles via pasientreiser tlf. 05515. Utgifter til transport dekkes av pasientreiser i ettertid.

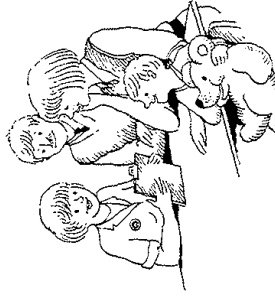
EGENANDEL

Det er ingen egenandel i forhold til undersøkelse/behandling for deg som er dagpasient.



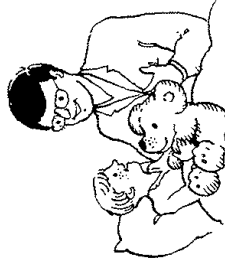
PÅ DAGENHETEN DRAGEN

Når du kommer til oss blir du møtt av en sykepleier. Hun snakker med deg og pårørende, og forteller hva som skal skje videre. Hun vil veie og måle deg. På noen vil også temperaturen bli målt.



VENTETID

Det kan bli litt tid å vente før undersøkelsen/behandlingen starter. Mens du venter kan du gå på lekestua, skolen eller venterommet.



MAT OG DRIKKE

Sykehuset dekker ikke matutgifter til pårørende. Ta gjerne med matpakke. Vi serverer te/kaffe til pårørende, og drikke evt. mat til barma. Narvesen (plan 6) er åpen hele dagen. Kafé Evert (plan 3) er åpen fra kl. 09.00 – kl. 15.00.

LEGEN

Det kommer en lege for å prate med dere, og undersøke deg litt. Pårørende er sammen med deg hele tiden. Som regel får dere ikke svar på undersøkelsen samme dag, men vil bli tilskrevet eller innkalt til ny time hos en lege i barnepoliklinikken.



UNDERSØKELSE I SEDERING ELLER MED LIKEGLADMEDISIN

SEDERING

Det er det samme som at barnet får sovemiddel for å kunne ligge helt stille mens en undersøkelse pågår. Medikamentene som brukes, blir oftest gitt i munnen.

FORBEREDELSE

Barnet skal være **fastende**, men kan spise **inntil 3 timer før** undersøkelsen. For evt. å ta medisiner kan man drikke ½ glass vann. Fordi vi trenger venekanyler, får barnet bedøvende krem før det legges inn venflon (et lite plastrør) i en blodåre.

GJENNOMFØRING

Dere som påtørende kjenner barnet best. For at undersøkelsen skal bli vellykket er vi avhengige av hjelp fra dere. Sykepleier og påtørende samarbeider om å berolige barnet. Ta med kosedyr, smokk eller annet som barnet bruker når det skal sove.

ETTER UNDERSØKELSEN

Kan barnet stå opp, spise og drikke så snart det er våkent.

LIKEGLADMEDISIN

Gir vi hvis barnet skal til en undersøkelse hvor det ikke skal sove, og vi ser at vi ikke får til et samarbeid. Barnet får da en lett rus, og blir mer samarbeidsvillig. Medikamentet gis da i munnen like før undersøkelsen. Barnet skal faste ca. 1 time før likegladsmedisinen gis.



SLIK KAN VI KONTAKTES FØR ELLER ETTER DAGOPPHOLDET:

Dagenheten Dragen:
Tlf.: kl. 08.00 –15.00
77 66 93 00 – Sekretær
77 66 98 86 – Postsekretær

Sykepleiere har tlf. tid fra kl. 12.30,
tlf. 77 66 92 92

Vi kan også kontaktes via

E-post:
barneavd-dagenhetendragen
@umn.no

Dersom dere har behov for å gi beskjeder eller har spørsmål angående dagoppholdet kan dere ringe oss i telefontiden.

Dersom det ikke passer for dere å komme må sekretær/postsekretær få beskjed i god tid.

Ved sykdom gi beskjed så snart som mulig.
Dere er også velkommen til å ringe oss etter at dere er kommet hjem.



LITTERATUR

Vi kan anbefale følgende bøker som dere kan lese sammen for dere kommer til oss:

- " Thomas hos doktoren " Gunilla Volde, Aschehoug 1977.
- " Nysgjerrige Nils på sykehus " Margareth & H. A. Ray
- «Gjør meg bra, sa Marius» Inger og Lasse Sandberg, Aschehoug 1990.
- «Au... det gjør vondt» Kari og Werner Grossmann, Gyldendal 2004.



**TIL BARN OG
FORELDRE**



**MÁNÁIDE JA
VÁHNEMIIDDA**

Universitetssykehuset Nord-Norge
Davvi-Norgga universitehtabuohcceviessu



INFORMASJON TIL BARN OG FORELDRE

Deres barn har nå fått innkallelse til operasjon ved UNN. For å forberede barnet på sykehusoppholdet, ber vi dere sette av tid til å lese denne brosjyren ilag med barnet. Barn trenger ofte god tid til å forberede seg, og dere bør starte ca. 1 uke før sykehusoppholdet. Dette kan med fordel gjentas flere ganger før oppholdet. En av foreldrene får være sammen med barnet under hele oppholdet.

Dersom barnet skal overnatte på sykehuset, må det forberedes på dette. Barnet kan f.eks. selv pakke sekken med nattøy og noen kjære leker.

Mange barn er redde for blodprøven - ikke bare for stikket, men også for at de skal miste alt blodet sitt. Dere kan derfor forklare barnet at blod lages på nytt. For større barn er det lurt å peke på det området som skal opereres, og samtidig forklare at huden vil gro.

På sykehuset går personalet fra anestesivdelingen på besøk til de barna som skal opereres neste dag. Vi ber dere derfor ta med denne brosjyren til sykehuset.

Vel møtt.

DIEHTUN MÁNÁIDE JA VÁHNEMIIDDA

Dudno/du mánná lea ožžon gohččuma čuohtaheapmái UNN:s. Dábálač čat dárbašit mánát guhkes áiggi ráhkanit buohcceviesu dilálašvuhiti. Danin ávžžuhit dudno/du lohkat dán gihppaga ovttas mánáin, ja berrebeahtti/berret álgit sullii vahkku ovdal. Dan sáhtta geardduhit moddii ovdal vuolgima. Nubbi váhnen beassá leat máná luhtte olles áiggi.

Jos mánná galgá idjadit buohcceviesu, de berrebeahtti/berret su dasa ráhkanahhtit. Mánná sáhtta omd. ieš seahkas páhkket, ja váldit mielde idjábiktasiid ja muhtin ráhkis stohkosiid.

Ollu mánát ballet varraiskosa váldimis – eai bala duššefal čuggestagas, muhto sii ballet maid buot vara massimis. Mánnái sáhtta č ilget ahte rumaš ráhkada ođđa vara. Stuo-
rat mánáide sáhtta cuiget gokko galgá čuohtahuvvot, ja maddái čilget ahte liiki savvo manjil.

Buohcceviesu anestesijaossodaga bargit galledit mánáid geat galget čuohtahuvvot nuppe beaivvi. Danne bivdit din váldit dán gihppaga mielde buohccevissui.

Bures boahtin.

**Nina skal opereres...
Nina galgá čuohpahuvtot...**



Hei, jeg heter Nina
og skal på sykehuset
i dag.

Hei, mu namma lea Nina
ja mun lean odne vuolgi-
min buohceveissui.



En pleier møter oss på
barneavdelinga,
og viser meg hvor vi skal sove.

Mánáidossodagas čájeha
divššár munnje gos mii
galgat oadđt.

Og her er lekestua...

Dá lea
stoahkanlatnja...



Ná lytter doktoren
på hjertet mitt, og
jeg får også høre!

Dál guldala doavtír
mu váimmu. Mun
maid beasan gullat!



Jeg får bedøvelseskrem på
begge armene, for at det ikke
skal gjøre vondt når jeg skal
ta blodprøve.

Mun oačč un jámihanávdnasa
goappaš giedáide, amas
bávč čagit go varraisikosa váldet.



Jeg og mamma tok heisen og gikk bortover en lang gang for å ta blodprøven.



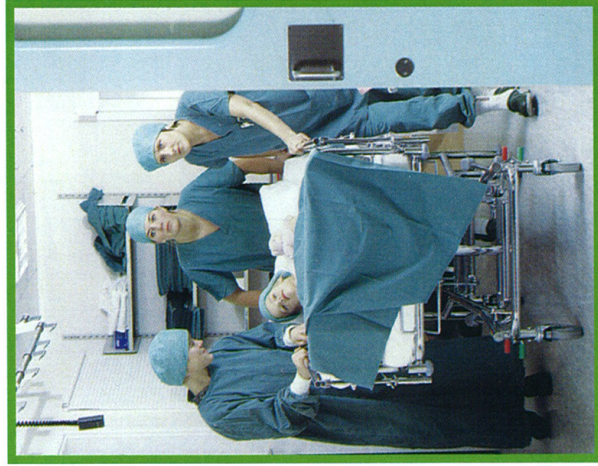
Moai etniin manaima heaissain ja vácciime guhkes feaskára mielde go mus galge váldit var-raiskosa.



Et plaster stikkes inn på hånden min. Bedøvelseskremen gjør at jeg ikke kjenner så mye.

Plástabohcci čuggejuvvo mu gihtii. Jámihanávn-nas dahká ahte in dovdda bákkása.

Her kjøres jeg inn på operasjonsstua, og mamma må ha på seg grønne klær når hun skal være med inn.



Dá dolvot mu čuohpahanlatnjii, ja eadni ferte coggat ruoná biktasiid go galgá mu mielde sisa.

Nå får jeg medisiner for å sove, og puster inn litt luft på en maske.



Dál galgan nohkkat, ja ferten vuognat háma čada.

På oppvåkningen

Når operasjonen er over og jeg har sovet ferdig, våkner jeg på oppvåkningsavdelingen. Diplomet som ligger på senga har jeg fått fordi jeg har vært så flink.



Morihanossodagas

Go čuohpahemiin leat geargan ja mun lean do-arvái oadđán, de morihan morihanossodagas. Diploma mii lea searngaravddas lean ožžon go lean leamaš nu čeahppi.

I dag reiser jeg hjem.



Odne vuolggán ruoktot.

Appendix 4



ROMSSA fylkkesuohkan
TROMS fylkeskommune



Tannhelsetjenestens
kompetansesenter for Nord-Norge

Informasjon etter et kirurgisk inngrep i munnhulen.

Etter en operasjon i munnen, kan det bli ømt og hovent i noen dager, man kan også bli litt gul, grønn eller blå på kinn og lepper.

For å unngå smerter dagene etter operasjon, anbefaler vi Ibux eller Paraseth hver 4 time, samme dag som behandlingen er gjort. Etter det, kan man ta smertestillende tabl når man trenger det.

Skyll eller tørk med en Q-tips dyppet i klorheksidin, for eksempel Corsodyl eller Hibitane (fåes kjøpt på apoteket) i en uke, eller til det går bra å børste tennene med tannbørste.

Eventuelle sting absorberes bort av seg selv, hvis de blir plagsomme, kan vi ta de vekk.

Vi vil gjerne ha en time til etterkontroll, vi avtaler tid.

Vi anbefaler pasienten å slappe av og ikke ha noen form for fysisk aktivitet de første dagene etterpå.

Hvis noe er uklart eller lurer på noe, er det bare å ringe oss på : 77 78 90 00, eller direkte vårt kontor: 77 78 91 12

Med vennligst hilsen

Pedodonti teamet v/ Pedodontist Eva Edblad.

References

- 1: Årsmelding for tannhelsetjenesten i Troms fylkeskommune 2009. 8.2 - 8.4, pp45-47
- 2: Årsmelding for tannhelsetjenesten i Troms fylkeskommune 2009. 4.1.2, p22
- 3: Hallonsten AL, Jensen B, Raadal M, Veerkamp J, Hosey MT, Poulsen S. EAPD Guidelines on sedation in Paediatric Dentistry. www.eapd.gr/8B927172.en.aspx
- 4: Klingberg G, Raadal M, Arnrup K. Dental fear and behavior management problems. In Koch G, Poulsen S eds. Pediatric dentistry. A clinical approach. Second edition. Oxford: Blackwell Publishing Ltd. 2009; p.39
- 5: Raadal M, Lundeberg S, Haukali G. Pain, pain control, and sedation. In Koch G, Poulsen S eds. Pediatric dentistry. A clinical approach. Second edition. Oxford: Blackwell Publishing Ltd. 2009; p. 54
- 6: Statens legemiddelverk: Benzodiazepiner for kontroll av angst og vegring ved tannbehandling. Terapi anbefaling. Publikasjon 2003:03
- 7: Gaynor WN, Thomson WM. Changes in young children's OHRQoL after dental treatment under general anaesthesia. Int J Paed Dent 2011. doi: 10.1111/j.1365-263X.2011.01190.x
- 8: Klassen MA, Veerkamp JS, Hoogstraten J. Young children's Oral Health-Related Quality of Life and dental fear after treatment under general anaesthesia: a randomized controlled trial. Eur J Oral Sci 2009; **117**: 273-278
- 9: Klingberg G, Raadal M, Arnrup K. Dental fear and behavior management problems. In Koch G, Poulsen S eds. Pediatric dentistry. A clinical approach. Second edition. Oxford: Blackwell Publishing Ltd. 2009; p.36
- 10: Weinstein P et al. Situation – specific child control. A visit to the dentist. Behav Res Ther 1996; **34**:11- 21
- 11: Raadal M, Lundeberg S, Haukali G. Pain, pain control, and sedation. In Koch G, Poulsen S eds. Pediatric dentistry. A clinical approach. Second edition. Oxford: Blackwell Publishing Ltd. 2009; p. 44
- 12: Klingberg G, Broberg AG. Dental fear/anxiety and dental behaviour management problems in children and adolescents: a review of prevalence and concomitant psychological factors. Int J Paed Dent 2007; **17**:391-406
- 13: Klingberg G, Raadal M, Arnrup K. Dental fear and behavior management problems. In Koch G, Poulsen S eds. Pediatric dentistry. A clinical approach. Second edition. Oxford: Blackwell Publishing Ltd. 2009; p.35

- 14: Klingberg G, Raadal M, Arnrup K. Dental fear and behavior management problems. In Koch G, Poulsen S eds. Pediatric dentistry. A clinical approach. Second edition. Oxford: Blackwell Publishing Ltd. 2009; p.38
- 15: Arnrup K, Broberg AG, Berggren U, Bodin L. Lack of cooperation in pediatric dentistry – the role of child personality characteristics. *Pediatr Dent* 2002; **24**:119-128
- 16: Årsmelding for tannhelsetjenesten i Troms fylkeskommune 2009. 1.1.3, p17
- 17: Veerkamp JS, Gruythuysen RJ, Hoogstraten J, van Amerongen WE. Anxiety reduction with nitrous oxide: a permanent solution? *ASDJ J Dent Child* 1995; **62**:44-8
- 18: Verbal communication with Public Dental Health Service, Elin Nilsen
- 19: Kakaounaki E, Tahmassebi JF, Fayle SA. Repeat general anaesthesia, a 6-year follow up. *Int J Paed Dent* 2011; **21**:126-131
- 20: Årsmelding for tannhelsetjenesten i Troms fylkeskommune 2009. 4.1.2, p23