



- Alternative low-risk routes of delivery such as intraligamentary single-tooth anesthesia (STA) or buccal infiltration injections are effective alternatives to inferior alveolar nerve blocks (IDB).^{84,86}
- Other nonsurgical dental procedures carry variable levels of bleeding risk. Most restorative dental procedures such as dental fillings are low risk and can be carried out without the need for factor replacement therapy.
- Minimally invasive buccal infiltration or intraligamentary injections and techniques to protect soft tissues should be used, and standard local measures to aid mucosal hemostasis should be applied as appropriate.
- Professional dental cleanings can be provided with the use of antifibrinolytic agents, if necessary.⁸²

Recommendation 2.7.7:

- For patients with hemophilia, the WFH recommends that dental extraction or other invasive procedures within the oral cavity (e.g., dental implantation, periodontal surgery, or gum biopsy) be performed only with a personalized plan for hemostasis management in consultation with a hematologist. **CB**

Recommendation 2.7.8:

- For patients with hemophilia, the WFH recommends the use of systemic or topical tranexamic acid or epsilon aminocaproic acid (EACA) as adjunct treatment in the management of dental interventions pre- and postoperatively, to reduce the need for factor replacement therapy. **CB**

Recommendation 2.7.9:

- For patients with hemophilia requiring dental extractions, the WFH recommends local hemostatic measures. Typical procedures include wound suture, topical use of antifibrinolytics, oxidized cellulose, and fibrin sealant, applied as appropriate.
- **REMARK:** Patients should be advised to maintain a soft diet and undertake careful brushing around the wound site for a minimum of 3-5 days postoperatively to avoid disturbing the clot and wound healing within the tooth socket. **CB**

Recommendation 2.7.10:

- For patients with hemophilia, the WFH recommends appropriate local anesthesia for dental treatments as an essential part of pain and anxiety management. Most dental injections pose a low risk for patients with hemophilia when delivered by a dental care professional using local anesthesia with a vasoconstrictor, and when the agent is delivered slowly with a single-use fine-gauge needle. **CB**

Recommendation 2.7.11:

- For patients with hemophilia requiring higher-risk intramuscular oral injections commonly associated with the provision of surgical dentistry (such as inferior alveolar dental block [IDB], superior alveolar nerve block, or injections in the floor of the mouth or vascular lingual tissues), the WFH recommends systemic

hemostatic measures preoperatively to avoid the risk of hematoma. These measures should be established in consultation with the hematologist.

- **REMARK:** The availability and effectiveness of alternative low-risk routes of local anesthetic delivery (such as intraligamentary single-tooth anesthesia, or buccal infiltration injections with 4% articaine) are effective alternatives to IDB and permit dental procedures in primary and permanent mandibular molar teeth. **CB**

Recommendation 2.7.12:

- For patients with hemophilia, the WFH recommends the use of antifibrinolytic agents as effective adjunct treatment in the management of dental hygiene therapies that facilitates access to regular dental care delivered by a dental hygienist. **CB**

Recommendation 2.7.13:

- In patients with hemophilia, the WFH asserts that the presence of blood-borne infections does not affect the safety of dental treatment as stringent universal cross-infection procedures are now mandatory across all disciplines of dentistry and recommends the provision of full dental services regardless of infectivity or immunological status. **CB**

2.8 | Transition from pediatric to adult care

- At different life stages, people with hemophilia and their caregivers go through transitions that involve transfer of care beyond the family, such as when a young person with hemophilia starts school, a new sport or leisure activities, and adolescence, and when moving from pediatric to adult medical care, moving away from home, starting new relationships, and making career choices.⁵¹
- Parents and/or caregivers typically assume primary responsibility for the management of care for children and adolescents with hemophilia; in particular, for administering treatment and maintaining adherence to therapeutic regimens.⁵¹
- Two transition periods are particularly challenging for treatment adherence: when adolescents switch to self-treatment; and when young adults move away from home and assume full responsibility for self-care.⁵¹ Many children and adolescents with hemophilia on prophylaxis who receive excellent comprehensive care do not experience the serious sequelae of their disorder, which may result in complacency in young adulthood.⁸⁷
- Ideally, young people with hemophilia should obtain the necessary knowledge and skills for self-management before transitioning to adult care; however, many young people still require parental assistance with hemophilia care even in their later teenage years.⁸⁷
- Adherence to prophylaxis has been found to be suboptimal in many adolescents (13-17 years of age) and young adults (18-30 years of age) with hemophilia.⁵¹
- In general, the main barriers to adherence to prophylaxis include high perceived burden of treatment; no or low burden of bleeds