

Expert Consensus on the Emergency Treatment of Oral Bleeding

Chinese Stomatological Association Group Standards T/CHSA 098-2025, Society of Oral Emergency, Chinese Stomatological Association

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Oral bleeding refers to haemorrhage occurring in the oral and maxillofacial region that does not stop spontaneously, resulting from either local factors, such as inflammation, trauma or tumours, or systemic conditions, such as haematological diseases, severe liver dysfunction or drug-related coagulopathy. Due to the abundant vascular supply in this region, blood loss can be substantial. Moreover, the admixture of blood with saliva often leads patients to mistakenly perceive the haemorrhage as more severe than it is, inducing significant anxiety. Patients with major maxillofacial trauma or systemic coagulation disorders may develop life-threatening complications including airway obstruction and hypovolemic shock. This consensus provides a framework for the emergency management of oral bleeding, encompassing pre-examination triage, principles and protocols for emergency treatment and site-specific recommendations for managing common oral haemorrhages. The aim is to standardise emergency care, assist clinicians in rapidly identifying critical conditions, achieve prompt haemostasis and ultimately improve the safety and efficiency of emergency management for patients with oral bleeding. This document is developed based on a review of the relevant literature and current clinical practices in select medical institutions and may be adapted according to the resources and circumstances of individual health care settings.

Keywords: consensus, emergency management, emergency triage, oral bleeding, oral haemostasis

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Preface

This document was prepared in accordance with the provisions of GB/T 1.1-2020 “Guidelines for Standardization Work Part 1: Structure and Drafting Rules of Standards”. It was proposed by the Society of Oral Emergency and was under the jurisdiction of the Chinese Stomatological Association.

Oral bleeding is defined as bleeding within the oral and maxillofacial region, resulting from local or systemic factors, that does not stop spontaneously and requires medical intervention. Local factors include inflammatory, traumatic and malignant or vascular tumours or vascular malformations in the oral and maxillofacial region.¹ Systemic factors encompass haematological disorders and severe liver disease,² drug-related bleeding^{2,3} and coagulation disorders caused by other systemic diseases.

Approximately 2.38% to 8.76% of patients come to the dental emergency department for oral bleeding.^{4,7} Due to the rich blood supply in the oral and maxillofacial region, the amount of bleeding is relatively high, and a large amount of saliva mixed with blood can lead patients to mistakenly believe that they are bleeding excessively, resulting in anxiety and panic. Patients often seek urgent medical attention, requiring emergency physicians to promptly reassure them and calmly estimate the actual

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amount of bleeding. At the same time, some patients with severe maxillofacial trauma or systemic factors leading to coagulation dysfunction may develop life-threatening complications such as airway obstruction or hypovolemic shock. It is essential that the emergency physician quickly identify the cause of oral bleeding in patients and determine the priority level of treatment.

This consensus is formulated based on relevant literature and combined with the current clinical practices of some medical institutions. Each medical institution may adopt it according to its own medical resource allocation.

Scope

This consensus proposes pre-examination triage levels, emergency treatment principles of patients with oral bleeding and emergency treatment recommendations for common sites of oral bleeding. This consensus serves as a reference for oral clinicians to consult and draw upon.

Normative references

The contents of the following documents are incorporated by way of normative references and constitute indispensable provisions of this document. For documents with specified dates, only the version dated accordingly is applicable to this document. For documents without specified dates, the latest version (including all amendments) is applicable.

Treatment principles for patients with oral bleeding

Initial haemostasis

Upon receiving patients with oral bleeding, pre-examination personnel should immediately perform initial haemostasis.

For patients with active oral and maxillofacial bleeding due to trauma, surgery or malignant tumours, temporary haemostatic methods such as finger pressure or gauze packing can be used for initial haemostasis. These measures help slow the bleeding rate and gain time for subsequent rescue and treatment.

For patients with mucosal bleeding in the oral cavity, subcutaneous bleeding or haematomas in the maxillofacial region, the underlying cause should be promptly identified and close monitoring should be conducted to observe whether the bleeding area shows progressive changes within a short period of time.

Grading judgment

Referring to the four-level pre-examination triage standards of the “Expert consensus of pre-examination triage in emergency department” of the Chinese Journal of Emergency Medicine⁸ and the “Expert consensus of pre-examination triage in oral emergency department”, grading is determined according to the principle of “urgent and serious priority”, with patients seen in the order of Level I, Level II, Level III and Level IV. Due to the high occupational exposure risk for contact with patients experiencing oral bleeding, to prevent cross-infection, medical staff should ensure their own protection by properly wearing masks, caps, gloves and protective face shields.

Level I refers to critically endangered patients who are experiencing or about to face life-threatening situations or rapid clinical deterioration, including abnormal vital signs such as cardiac/respiratory arrest or unstable rhythm, acute respiratory obstruction, hypovolemic shock and acute consciousness disorders/unresponsiveness. Such patients require immediate transfer to the emergency room for active intervention.

Level II refers to severely critical patients with severe or rapidly deteriorating conditions, where delays in treatment may endanger life or lead to severe organ dysfunction or where immediate treatment can significantly improve prognosis, including massive bleeding due to rupture of vascular tumours or malignant tumours in the oral and maxillofacial region, requiring rapid monitoring of vital signs, arranging for the patient to enter the resuscitation room or requesting emergency consultations as necessary.

Level III refers to patients requiring emergency prioritisation. Although their conditions are not life-threatening, they may develop adverse outcomes without timely intervention within a short period, including post-extraction bleeding, gingival bleeding and bleeding from oral surgical wounds. These patients require priority admission and local haemostasis.

Level IV refers to general emergency or non-emergency patients, indicating stable vital signs in oral emergency patients and non-emergency patients, such as those with no active bleeding in the oral cavity. Even if treatment is delayed for a period of time, it will not have a significant impact on prognosis, and patients can be managed sequentially in order of registration.

Principles for Level I and Level II patients

For Level I and Level II patients, initiate emergency response procedures immediately, open a green channel

and mobilise resources to provide emergency treatment in the emergency room or resuscitation room without delay. Assess vital signs, prevent and treat shock or asphyxia and determine if the patient has open wounds or active bleeding in the oral and maxillofacial region. After urgent rescue measures are implemented, the patient should be transferred to the relevant department or a higher-level hospital for treatment in a timely manner once their condition stabilises.

Principles for Level III and Level IV patients

Level III and Level IV patients can go to the oral emergency room or dental department. The attending physician will assess their overall condition, inquire about their medical history, provide reassurance, identify the source of bleeding and implement corresponding haemostasis measures based on the location, source and severity of bleeding. When medical resources and equipment are available, laboratory tests should be conducted. If laboratory test results indicate a risk of bleeding or if the patient's overall condition is poor, timely referral should be considered based on the specific circumstances. When primary care units or dental specialist hospitals do not have laboratory testing capabilities, after providing local haemostasis measures, patients should be advised to go to higher-level medical institutions or comprehensive hospitals for further laboratory testing.

Emergency treatment protocol for oral bleeding patients

Protocol for Level I and Level II patients

According to section 5.4 of T/CHSA 086-2024 "Expert consensus of pre-examination triage in oral emergency department".

Protocol for Level III and Level IV patients

Emotional support

For Level III and Level IV patients, oral bleeding often creates an illusion of heavy bleeding due to the blood being mixed with a large amount of saliva and frequent mouth rinsing by the patient, leading to feelings of anxiety and tension. Physicians should patiently explain the situation to the patient, stabilise their emotions and facilitate subsequent haemostasis procedures. Additionally, the tension and anxiety caused by bleeding, coupled with inadequate food intake, may trigger hypoglycaemia

or orthostatic hypotension in patients. Therefore, when examining patients with oral bleeding, it is important to first place them in a sitting or semi-recumbent position to prevent syncope.

Medical history collection

After taking initial haemostasis measures, it is necessary to inquire in detail about the patient's present medical history, past medical history/systemic review, family history, medication history, history of toxic substance exposure, etc. In the present medical history, ask about the bleeding situation, including its duration, nature and estimated amount. Depending on the situation, decide whether intravenous infusion or even blood transfusion is necessary. Inquire about bleeding in other parts of the body, such as subcutaneous petechiae, ecchymosis and haematomas. Ask if the patient has undergone any recent invasive oral procedures or surgeries, such as tooth extraction, periodontal scaling, mucogingival surgery or cyst or mass resection, and whether they followed the postoperative medical advice, including behaviours that may lead to postoperative bleeding, such as brushing teeth within 24 hours or sucking on the wound. Ask if there has been any recent trauma to the oral and maxillofacial region and whether the patient has consumed hot, hard or rough foods. In the past medical history, inquire about any history of spontaneous bleeding and whether the patient has systemic diseases such as hypertension, blood disorders, liver disease, end-stage renal disease or renal replacement therapy that may cause persistent bleeding. For women, inquire about their menstrual history and whether there is menorrhagia, etc. When considering family history, ask if any family members have a history of unexplained bleeding or haemophilia. With regard to medication history, focus on anti-platelet drugs and anticoagulants.⁹ Other types of drugs such as broad-spectrum antibiotics can affect coagulation factor activation by inhibiting intestinal flora and reducing vitamin K synthesis.¹⁰ Certain anticancer drugs can reduce platelet production by inhibiting bone marrow, affecting coagulation function.¹¹ If there is a history of toxic substance exposure, pay attention to rodenticides or snake venom and snake venom derivatives.

Physical examination

For oral and maxillofacial bleeding, observe if there are any open wounds, erosions or masses at the bleeding site. Check if there is swelling in the floor of the mouth and inspect the skin of the oral and maxillofacial re-

gion as well as other parts of the body for petechiae or ecchymosis.

In the case of intraoral bleeding, remove any blood clots in the oral cavity and examine carefully under good lighting and using a saliva suction device¹² to determine the exact location, scope and nature of bleeding, including the rate of bleeding, blood colour and whether there is pulsatile bleeding, etc.

Targeted haemostasis

Based on the location, source and severity of the bleeding, local compression, suturing or ligation should be applied to achieve haemostasis.

For open, penetrating wounds or sinus cavity bleeding, pack with iodoform gauze or petrolatum gauze and apply pressure bandaging if necessary. When packing neck or floor of mouth wounds, ensure airway patency to prevent suffocation.

For bleeding from capillaries or small veins and arteries or oozing wounds, first clean the wound, reset the soft tissues, then cover or pack with absorbable gelatin sponge, apply multiple layers of gauze dressing and apply pressure bandaging. Pay attention to the appropriate pressure of the bandage to avoid local skin ischemia or exacerbating displacement of bone fractures and affecting airway patency.

The severed ends of blood vessels that are actively bleeding in the wound should be clamped with vascular clamps for ligation or suturing to stop bleeding. For severe bleeding in the oral and maxillofacial region, if local bleeding cannot be properly stopped, ligation of the external carotid artery may be considered.

Laboratory tests

When medical conditions permit, laboratory tests should be conducted for patients experiencing oral bleeding, primarily complete blood count (CBC) and coagulation function tests.

The CBC examination primarily focuses on platelet count (PLT). The normal range for PLT is defined as $(125 \text{ to } 350) \times 10^9/\text{l}$. When PLT is less than $100 \times 10^9/\text{l}$, it is defined as thrombocytopenia.¹³ When PLT is $< 50 \times 10^9/\text{l}$, there is an extremely high risk of spontaneous bleeding, which can lead to serious clinical consequences. In particular, bleeding in any part of the central nervous system may cause severe neurological complications.¹⁴ When PLT is less than $30 \times 10^9/\text{l}$, this is defined as severe thrombocytopenia, and urgent consultation with the haematology department is recommended.¹³ When PLT is less than $10 \times 10^9/\text{l}$, the

situation is considered high risk, and immediate action should be taken to transfer the patient to the haematology emergency department with the assistance of family members.

Coagulation function tests focus on prothrombin time (PT), activated partial thromboplastin time (APTT), fibrinogen (Fg) and international normalised ratio (INR). PT and APTT greater than 1.5 times the upper limit of normal or fibrinogen less than 1 g/l indicate haemostasis failure and microvascular bleeding. Especially in cases of major bleeding, when fibrinogen is less than 1 g/l, haemostasis is difficult to improve, and urgent consultation with the haematology department is recommended. Fg levels greater than 1.5 g/l may further improve haemostasis. INR monitoring is commonly used to assess the coagulation function of patients taking oral anticoagulants. According to the 2023 Expert Consensus on Critical Values of Hemorrhagic Diseases, an INR of ≥ 3.5 is defined as a clinical critical threshold and requires close monitoring.¹⁴ If INR is greater than 3.5, medication should be adjusted by an intern.

For patients with significant blood loss, it is advisable to promptly complete whole blood and plasma electrolyte tests to identify and correct secondary problems such as hypovolemic shock and acid-base imbalance.

Hospital observation or timely referral

After haemostasis, patients experiencing general bleeding should be observed for at least half an hour. If there is no active bleeding upon examination and no significant abnormalities in laboratory tests, they can be discharged. Patients should be advised not to brush their teeth or rinse vigorously for 24 hours, and they should try to eat cool and soft foods to reduce irritation to the bleeding wound.

Patients with severe conditions should be transferred to the relevant departments for further treatment after initial assessment and haemostasis. If medical conditions are inadequate, if there are critical values in laboratory test results or if the patient's general condition is poor, timely referral or hospital transfer should be arranged based on the specific situation.

Treatment recommendations for common sites of oral bleeding

Bleeding from extraction sites

Bleeding from extraction sites is a well-recognised common post-extraction complication. Local factors include

inaccurate placement of gauze or cotton balls, gingival tears, residual inflammatory granulation tissue in the socket, alveolar bone fractures, vascular rupture, displacement of blood clots and postoperative infections.¹⁵

Treatment recommendations

Remove blood clots and identify the bleeding site and cause. Carefully remove any blood clots higher than the socket and excess clots in the mouth using forceps and gauze to ensure a clear view. Carefully examine the condition of the extraction socket and quickly remove the gauze or cotton pellet after compressing the wound to identify the bleeding point and its source. Additionally, observe for any soft tissue tearing around the extraction site, the presence of alveolar bone fractures and any blood clots in the socket.

Implement different approaches based on the cause of bleeding. For gingival or mucosal tears, perform suturing to approximate the torn gingiva, ensuring that the sutures penetrate the full thickness of the gingiva.¹⁶ For incomplete removal of inflammatory granulation tissue, under local anaesthesia, scrape away any remaining inflammatory granulation tissue in the extraction socket. If there are any bone or tooth fragments, remove them as well. After packing the wound with gelatine sponge, instruct the patient to bite down on gauze or a cotton ball. In the event of bleeding from bone holes in the socket, pack the wound tightly with iodoform gauze. Instruct the patient to bite down for pressure and advise them to have the iodoform gauze removed 7 to 10 days later.¹

Determine whether the patient needs to be hospitalised for observation after achieving haemostasis based on the specific situation. Extraction of the mandibular third molars may cause haematoma formation in the floor of the mouth due to extensive soft tissue damage. For patients at risk of sublingual haematoma, closely monitor their respiratory status. If swelling of the floor of the mouth worsens progressively, elevating the base of the tongue and causing airway obstruction, immediate tracheal intubation or tracheostomy may be necessary. If feasible, recommend completing blood tests, including CBC and coagulation function tests, and consult the relevant departments promptly if abnormalities are detected.

Gingival bleeding

Gingival bleeding is one of the common reasons for emergency dental visits. Local factors include chronic gingival inflammation and damage to the gingiva after

periodontal treatment. Gingival bleeding caused by central haemangioma of the jaw is rare, but the consequences may be very serious. The principle and procedures of clinical management are based on the protocol for Level I and Level II patients. Additionally, some blood system disorders may manifest as gingival bleeding, so spontaneous gingival bleeding patients should be given high attention by emergency dental physicians.

Treatment recommendations

Remove blood clots and locate the bleeding point for haemostasis. If gingival bleeding occurs at the gingival papilla, irrigate the gingival sulcus alternately with 1% to 3% hydrogen peroxide and normal saline or apply pressure to the gingival papilla with cotton soaked in hydrogen peroxide, and then locally pack small pieces of gelatine sponge and apply pressure with gauze to stop bleeding. If gingival bleeding occurs in the gingival sulcus, locally apply periodontal dressing for haemostasis. If bleeding continues or periodontal dressing is unavailable, tightly pack the gingival sulcus with trimmed strips of iodoform gauze and apply pressure to stop bleeding. If obvious calculus is detected at the bleeding point, perform local scaling before haemostasis. In the case of gingival bleeding caused by gingival tumours, with a large amount of bleeding and pulsatile flow, periodontal dressing or tight packing with iodoform gauze after suturing can be used for haemostasis.

If feasible, recommend completing blood tests, including CBC and coagulation function tests, and consult the relevant departments promptly if abnormalities are detected.

Patients should be observed in the hospital for at least 30 minutes after haemostasis intervention.

Palatal postoperative bleeding

In implant or periodontal-related surgeries, damage to branches of the greater palatine neurovascular bundle can lead to postoperative bleeding in the palatal donor site.

Treatment recommendations

Remove blood clots and apply wet gauze to compress the bleeding site for 5 to 10 minutes. If bleeding persists, electrocoagulation may be performed if conditions allow.¹⁷ Alternatively, ligation of the greater palatine neurovascular bundle or its terminal branches in the distal region of the donor site can be performed.¹⁸ If the colour of the mucosa in the sutured and donor site turns

pale, this indicates successful ligation of the greater palatine neurovascular bundle, resulting in an immediate reduction in bleeding.¹⁹ Packing with iodoform gauze or using a palatal stent to fix iodoform gauze for compression are common and effective management measures.

Mucosal blood blisters

Mucosal submucosal bleeding caused by the rupture of mucosal capillaries due to scalding during eating, accidental biting or abrasions from consuming rough or hard foods is described as traumatic mucosal blood blisters. Disorders such as coagulation abnormalities, hypersensitivity reactions, pemphigus and pemphigoid may also cause oral mucosal blood blisters, but traumatic forms are more common in dental emergencies.

Treatment recommendations

For small blood blisters that do not affect eating, no treatment is necessary as they typically resolve on their own within a week. Patients should be advised not to intentionally rupture the blister to avoid secondary infection. For larger blood blisters with obvious foreign body sensation and that are affecting eating and swallowing, the contents can be aspirated with a sterilised needle. If the blood inside the blister has already coagulated and is difficult to aspirate, an incision can be made at the lowest point of the blister to remove the contents. It is important to preserve the integrity of the blister wall as much as possible to protect the wound. Local application of antibacterial, anti-inflammatory and analgesic medications can be used to treat the wound. If there are sharp cusps, residual roots or crowns or poorly fitted restorations irritating the mucosa around the blister, they should be adjusted or removed promptly.

Oral and maxillofacial postoperative mucosal/subcutaneous bleeding

Postoperative mucosal/subcutaneous bleeding in the oral and maxillofacial region is often caused by injury to small blood vessels during surgery or improper compression and haemostasis. In implant surgery, extensive dissection of the mucosa or large injury to the mucoperiosteum may also result in mucosal/subcutaneous bleeding.

Treatment recommendations

For patients with loose subcutaneous tissue, blood and tissue exudate can easily permeate surrounding tissues,

leading to bruising in the maxillofacial region or even the neck. Subcutaneous bruising typically resolves on its own within 1 to 2 weeks without specific treatment, with the main focus on infection prevention. Physicians should inform patients about the course of subcutaneous haematoma to avoid panic. Patients should be advised to apply intermittent cold packs for 24 to 48 hours post-operatively, followed by intermittent warm compresses after 72 hours to promote haematoma absorption. If subcutaneous bruising worsens over time, consideration should be given to systemic factors, and referral to the relevant departments for further evaluation is recommended.

Oral and maxillofacial haematoma

Most maxillary haematomas are caused by trauma, with iatrogenic injuries commonly occurring during posterior superior alveolar nerve block anaesthesia and occasionally seen in local infiltration anaesthesia in the posterior maxillary tooth area.

Treatment recommendations

Inform the patient about the progression of the haematoma to avoid panic. Generally, subcutaneous haematoma turns from green to yellow after 5 to 7 days and is completely absorbed in about 2 weeks without special treatment, primarily to prevent infection.²⁰ Patients can apply intermittent cold packs 24 to 48 hours after surgery, followed by intermittent warm packs after 72 hours to promote haematoma absorption.

Floor-of-mouth haematoma

Floor-of-mouth haematomas are often caused by trauma to the base of the tongue or iatrogenic injuries, such as during the extraction of the mandibular third molars or implant procedures in the anterior mandible, leading to the inadvertent injury of floor-of-mouth vessels, which can result in haematoma formation. This condition can compromise airway patency and even lead to asphyxiation, posing a life-threatening situation.²¹ Therefore, patients with floor-of-mouth haematomas require close attention, with the primary management principle being to ensure airway patency.²²

Treatment recommendations

Monitor vital signs: pay attention to whether the patient is conscious, assess for signs of tachycardia or a weak pulse or the presence of respiratory distress or cyanosis

and any progressive decrease in or low blood pressure, and promptly identify issues, determine the cause and provide emergency treatment.

Maintain airway patency: floor-of-mouth haematoma can rapidly spread in the loose tissues beneath the tongue, leading to airway obstruction. Therefore, closely monitor airway patency. If the patient exhibits significant respiratory distress, immediately insert a nasal airway tube. In emergency situations, perform a cricothyrotomy/tracheostomy to promptly relieve asphyxia.²³

Perform local examination to observe whether the haematoma is progressively enlarging and if its size affects the patient's daily activities.

Determine the treatment approach based on the severity and progression of the hematoma.²⁴ If the hematoma increases progressively increases, first perform local compression in the floor of the mouth and the lingual side of the mandible in both directions to stop bleeding.²⁴ If the bleeding is still uncontrollable, this indicates that the damaged blood vessels are larger branches, and local compression is difficult to stop bleeding completely. Exploration and ligation of bleeding blood vessels in the surgical area or electrocautery are the most reliable methods to stop bleeding.²⁵ The surgical area is opened, the blood clot and blood are sucked out with a suction device, the bleeding point is found under bright light and the damaged blood vessels are ligated.²⁴ If the haematoma does not increase progressively and its size does not affect daily life, the bleeding is self-limiting, indicating that the damaged blood vessels are small branches, and the tension of the mucosal membrane at the floor of the mouth acts as a local compression to limit the further growth of the haematoma. No special treatment is needed. Early measures such as local cooling with ice chips can be used to comfort the patient, and vital signs should be monitored.²⁶ If the haematoma does not increase progressively but is too large and affects normal life: the floor-of-mouth haematoma can be removed under local anaesthesia. The mucosa is incised slightly lateral to the sublingual fold at the floor of the mouth, and blunt dissection is performed into the haematoma cavity to remove the blood coagulation. Rinse and expose the surgical area, search for active bleeding points and ligate the damaged blood vessels. After checking that there is no active bleeding, suture and place rubber strips for drainage. Anti-infective and haemostatic drug treatment will be given after surgery.²⁶

After haemostasis, determine whether the patient needs hospital observation based on the specific situation. The patient can be discharged if the haematoma

does not progressively enlarge or if there is no bleeding. Patients are instructed to pay close attention to the size of the purple swelling in the floor of the mouth after leaving the hospital, and if progressive enlargement is observed, they must seek immediate medical attention.²⁶

Conflicts of interest

The authors declare no conflicts of interest related to this study.

Author contribution

This document was drafted by experts from the Shanghai Ninth People's Hospital, Shanghai JiaoTong University School of Medicine. The consensus experts were from the Shanghai Ninth People's Hospital, the Third Affiliated Hospital of Air Force Military Medical University, Peking University School and Hospital of Stomatology, Beijing Stomatological Hospital, Hospital of Stomatology, SunYat-sen University, School of Stomatology, China Medical University Affiliated Stomatological Hospital, West China Hospital of Stomatology, Sichuan University, Stomatological Hospital Affiliated to Nanjing Medical University, Stomatology Center of Shaw Hospital Affiliated To Zhejiang University School of Medicine, First Medical Center of PLA General Hospital, Hospital of Stomatology Lanzhou University, 900 Hospital of the People's Liberation Army Joint Logistic Support Force, and the First Affiliated Hospital of Zhengzhou University participated in the drafting.

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