NHS England

Interim Clinical Commissioning Policy: Armed Forces Removal of Third Molar Teeth (Wisdom Teeth)

Agreed: November 2013

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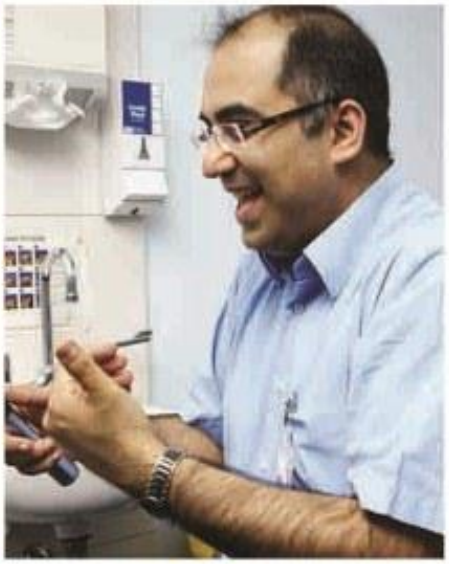

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Description	The set of non-specialised commissioning policies have been agreed by NHS England's Clinical Priority Advisory Group (CPAG) and approved by the Directly Commissioned Services Committee (DCSC) as interim policies for those populations we directly commission services for (namely the Serving Armed Forces & some families and those in detained settings)
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Superseded Docs (if applicable)	N/A
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Document Status

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Interim Clinical Commissioning Policy – Armed Forces

Removal of Third Molar Teeth (Wisdom Teeth)

First published: November 2013

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Contents

Policy Statement

NHS England will commission removals of 3rd molars in accordance with the criteria outlined in this document.

In creating this policy NHS England has reviewed this clinical condition and the options for its treatment. It has considered the place of this treatment in current clinical practice, whether scientific research has shown the treatment to be of benefit to patients, (including how any benefit is balanced against possible risks) and whether its use represents the best use of NHS resources.

This policy document outlines the arrangements for funding of this treatment for the population in England.

Equality Statement

NHS England has a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved as enshrined in the Health and Social Care Act 2012. NHS England is committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. In carrying out its functions, NHS England will have due regard to the different needs of protected equality groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

Plain Language Summary

Removal of wisdom teeth is one of the most common surgical procedures performed in the UK. In the past, a large number of wisdom teeth were removed before they caused people any problems (removed prophylactically). Guidance was issued on how to treat wisdom teeth that were symptom free, including the NICE Guidance on the Extraction of Wisdom Teeth (2000). NHS England will only commission the surgical removal of wisdom teeth where there is evidence of pathology. The removal of a diseased or symptomatic third molar tooth will alleviate pain and symptoms and improve oral health.

1. Introduction

Permanent molar teeth normally erupt from the age of six onwards, with the third molars (wisdom teeth) being the last to erupt, usually between the ages of eighteen and twenty four years. Wisdom teeth may erupt normally into correct dental alignment and function or conversely develop in non- or minimally functional positions. Impaction occurs when there is prevention of complete eruption due to lack of space, obstruction or development in an abnormal position. This may result in a tooth erupting partially or not at all. Wisdom teeth can also be impacted, either erupting partially or not at all. Impaction may be associated with pathological changes including pericoronitis, an increased risk of caries, cyst formation and periodontal disease in adjacent teeth, and orthodontic problems in later life (NICE 2000).

Removal of wisdom teeth is one of the most common surgical procedures performed in the UK. In the past the removal of impacted third molars causing pathological changes was accompanied by prophylactic removal of pathology-free impacted third molars. Wide variations in the rates of this latter procedure across the country occurred but up to 44% of wisdom teeth removals may have been inappropriate.

Following research publications and professional guidelines in the 1990s that advised against prophylactic surgery and provided specific therapeutic indications for surgery, the National Institute of Clinical Excellence (NICE) 'Guidance on the Extraction of Wisdom Teeth' was published In 2000.

The impact of the guidelines has not been fully evaluated, though there is evidence that referral and treatment patterns have changed.

2. Definitions

An **unerupted tooth** is a tooth lying within the jaws, entirely covered by soft tissue, and partially or completely covered by bone.

A **partially erupted tooth** is a tooth that has failed to erupt fully into a normal position. The term implies that the tooth is partly visible or in communication with the oral cavity.

An **impacted tooth** is a tooth which is prevented from completely erupting into a normal functional position. This may be due to lack of space, obstruction by another tooth, or an abnormal eruption path.

RCS (1997)

3. Aim and objectives

This policy aims to define eligibility criteria for the removal of third molar teeth commissioned by NHS England

4. Epidemiology and needs assessment

Impaction of third molars is a common condition, the prevalence being influenced by age, gender, ethnicity and skeletal face types.

The likelihood that an impacted lower third molar will develop symptoms in future is difficult to assess, but clinical characteristics such as the angulation, the degree of impaction and the patient's age may help predict future problems.

There is some evidence that during the 20-year period, 1989/1990 to 2009/2010, the proportion of impacted third molar surgery decreased from 80% to 50% of admitted hospital cases, with an increase in the mean age for surgical admissions from 25.5 to 31.8 years and an increase in caries and pericoronitis as etiologic factors rather than impaction.

Caution is needed, however, in data interpretation as coding and data collection is not uniform in secondary care and the recording of outpatient figures is variable. In addition, there has been an increase in the commissioning of extractions in a primary care setting which is not recorded in HES not always in NHSBSA data.

5. Evidence base

The evidence base underpinning this policy is outlined in the NICE (2000), and SIGN (2000) guidance and informed by literature listed in references.

6. Rationale behind the policy statement

The policy statement is in line with NICE (2000), and SIGN (2000) guidance

7. Criteria for commissioning

Surgical removal of impacted third molars should be limited to the following cases:

- unrestorable caries in the third molar, or when there is caries in the adjacent second molar tooth which cannot satisfactorily be treated without the removal of the third molar.
- untreatable pulpal or periapical pathology
- one or more episode of infection such as pericoronitis, cellulitis, abscess formation or osteomyelitis
- dentigerous cyst formation or other oral patholology e.g. tumour,
- Internal or external resorption of the third molar or adjacent teeth
- Tooth fracture
- In cases of periodontal disease due to the position of the third molar and its association with the second molar tooth
- Tooth / teeth impeding orthognathic surgery, reconstructive jaw surgery, or within the field of tumour resection.

Where there is pathology associated with the tooth, there is strong evidence that morbidity increases with age and there is no benefit in delaying treatment.

The clinician proposing this intervention will make the decision to treat based on the criteria set out above.

If the patient does not fully meet this criteria the clinician may submit an application for exceptional funding

(Individual funding request policy, application form and contact details on NHS Internet –http://www.england.nhs.uk/ourwork/d-com/policies/gp/)

An annual audit will be completed to confirm that patients have been treated in accordance with these criteria.

Indications may be modified by the general health of the patient

8. Patient pathway

Removal of wisdom teeth should routinely be undertaken in primary care.

Referral to secondary care services is appropriate only where the patient has significant medical co-morbidities or has risk factors complicating treatment that would pose a clinical risk if surgery were to be conducted in primary care.

9. Governance arrangements

This service will be provided by primary dental care providers. The service will be provided by secondary care service providers where this is deemed necessary.

10. Mechanism for funding

Funding will be provided through the relevant Area Team

11. Audit requirements

12. Documents which have informed this policy

NICE (2000), and SIGN (2000) guidance

13. Links to other policies

This policy follows the principles set out in the ethical framework that govern the commissioning of NHS healthcare and those policies dealing with the approach to experimental treatments and processes for the management of individual funding requests (IFR).

14. Date of review

This policy will be reviewed in April 2016 unless information is received which indicates that the proposed review date should be brought forward or delayed.

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Version Control Sheet

Version	Section/Para/Appendix	Version/Description of Amendments	Date	Author/Amended by
1	All sections	Transfer of content into new template and addition of information	11th September 2013	Ahmed Syed
2				
3				
4				
5				
6				