Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Department of Oral & Maxillofacial Surgery

Referral Guidelines

2015

To all General Dental Practitioners and General Medical Practitioners

The Department of Oral & Maxillofacial Surgery has outpatient clinics based at both Montagu Hospital, Mexborough and Doncaster Royal Infirmary. Day case operating is carried out at both of these sites and any emergency/inpatient operating is carried out at Rotherham NHS Foundation Trust.

These guidelines have been developed with reference to the NHS England "Referral Pathway – Minor Oral Surgery" document issued by the former South Yorkshire and Bassetlaw Area Team in March 2015.

In addition to the services offered by ourselves and the Intermediate Minor Oral Surgery Services (IMOS) located in the community, please be aware of the local Special Care Dentistry Service (CDS) and the Poswillo Service which provides a general anaesthetic extraction service for certain patient groups and where it is clinically appropriate to do so.

As part of the General Dental Service contract, NHS providers and performers are expected to carry out extractions of teeth including the removal of retained roots. The patient should only be referred if they present with special difficulties and lie outside the competence of the dentist concerned. NHS England have identified the inappropaite referral of extractions that should be carried out in practice as an area where improvements are necessary. If an individual performer feels unable to perform a procedure that should be carried out in general practice it is the responsibility of that provider to arrange for the procedure to be carried out in practice, by another, more experienced performer.

Where patients are referred for dento-alveolar surgery please ensure that relevant radiographs are enclosed with the referral, or they are available on the digital system at our Trust. If you do not have access to imaging such as DPT's then please arrange for patients to have the image taken **prior** to making the referral. If you have copies of intra-oral images then please send them with the original referral.
This will reduce the chances of an unnecessary radiation exposure to patients who are being assessed by us, and by arranging imaging prior to their referral will allow patients waiting times to be reduced.

If you feel that patients warrant a general anaesthetic or a general anaesthetic is indicated and the patient is genuinely phobic then consider referring them onto providers are able to manage these patients under conscious sedation. The majority of patients in this category will have had a bad experience from poorly managed previous extractions. If there is no surgical indication for general anaesthesia, it is more appropriate to manage anxious patients under local anaesthesia as a staged procedure in primary care. GDC guidelines indicate that "particular care must be taken when referring patients for treatment under general anaesthesia or sedation". General anaesthesia carries an increased level of risk and should not be offered to patients as a routine alternative.

If additional restorative dental treatment is being planned as part of the patients existing treatment plan, this treatment **must** be stated in the referral or completed prior to the patient's surgery being carried out. Please also indicate on the referral which additional teeth are planned to be restored and which do not need to be considered for extraction.

With regard to soft tissue lesions, we receive a significant number of 'intra-oral white or red patches' referrals with little clinical information. You will appreciate that without the clinical information it is difficult to triage these referrals appropriately, therefore please detail as much clinical information as possible in the referral to enable use to assess these patients.

Referrals can be sent electronically or in the post – details can be found within these guidelines. Please ensure that Rapid Access/Suspected Cancer referrals are sent on the separate Two Week Wait pathway and not as a routine referral marked 'urgent'.

Non-Third Molar Exodontia

The department does not provide a service for "routine" extractions in healthy patients, anxious patients, those with a history of difficult extractions or those with anticipated difficult extractions. If however, a surgical approach is necessary (e.g. retained roots) then a referral should be made.

Indications for exodontia referrals:

- Pathology associated with teeth/roots which requires histological analysis
- Extractions from abnormal or diseased bone (e.g. patients who have received therapeutic doses of irradiation to the jaws)
- Complicated extractions with special difficulty.
- Failed extractions with an explanation of why, and a 'post-extraction' radiograph.
- Extraction where there is a substantially increased risk of damage to an adjacent anatomical structure.

If a referral is made outside of these guidelines then the referring practitioner must justify the reasons why the treatment cannot be undertaken in primary dental care. It is rare for a patient's medical history to complicate the extraction to such an extent that it requires treatment in secondary care.

Please see the section on "Medical Reasons for Referral" .

Third Molars

The National Institute of Clinical Excellence (NICE) have published referral guidelines for third molars which are available on their website (http://publications.nice.org.uk/guidance-on-the-extraction-of-wisdom-teeth-ta1).

Asymptomatic third molars should not be extracted. Anterior crowding, if it occurs in the absence of any of the below, is not an indication for third molar removal.

Patients will normally only be offered surgical removal of third molars if they fulfil these guidelines. These include;

- Recurrent episodes of pericoronitis or a single episode of pericoronitis which showed evidence of spread and infection to the facial tissues.
- Caries not amenable to restoration.
- The third molar contributing to periodontal disease around the second molar.
- Peri-apical pathology
- Associated follicular cystic changes, and/or association with a cyst or tumour
- Prior to orthognathic surgery
- Resorption or caries of the adjacent teeth
- Association with a mandibular fracture

Management of Retained Roots

Long standing retained roots with no symptoms or infection present should not be referred.

Referral is only necessary where anatomical or pathology considerations make the extraction difficult, where the patient has medical complications or where previous attempts at extraction have failed.

Management of Teeth Requiring Endodontic Surgery/Apical Surgery

Prior to referral for apical surgery complete orthograde obturation of the root canal system must have taken place. Since there is good evidence to suggest that endodontic re-treatment has higher success rates than apical surgery, patients should be advised to pursue a non-surgical route if obturation is radiographically incomplete or short of the root apex. Non-surgical re-treatment should be the preferred option for endodontic failure.

Referral for apicectomy of a tooth with an inadequate root filling will not be accepted without exceptional circumstances.

Re-root filling by the referring dentist or a specialist Endodontist is the best solution to most failed root fillings.

Referral may be appropriate in cases of peri-radicular disesase in root filled teeth while orthograde endodontic therapy cannot be re-performed or has failed. Likewise, patients may be offered surgery in cases of suspect root perforation, root fracture or where biopsy of peri-radicular tissue is required (e.g. cystic change suspected).

Please see the Royal College of Surgeons England Guidelines for further details (www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/documents/surgical_endodontics_2012.pdf)

Management of Temporomandibular Joint Dysfunction

Initial management may involve supportive patient education on avoidance of clenching and grinding, relaxation and a soft diet.

Pharmacological pain relief with Non-Steroidal Anti-Inflammatory (NSAID's) and remedial jaw exercises can also be of value. For patients with persistent pain, stabilising splits or bite raising appliances may help, but permanent occlusal adjustments should be avoided.

The majority of patients presenting with TMJ problems will be suffering from TMJPDS (temporomandibular joint pain dysfunction syndrome) or myofascial pain. These patients can, in most cases be effectively managed in primary care without referral.

The most common symptoms are:

- Pain (usually a dull ache around the ear, it may radiate locally)
- Joint noise (e.g. clicking, cracking, crunching, grating or popping)
- Limited mouth opening
- Headache
- Facial swelling (some patients report this, mostly transient and can be worse in the morning)

Most cases of TMJPDS are made worse by chewing and are aggravated at times of stress.

Initial management in primary care includes the following measures:

1. Explanation of the condition and provision of written literature

2. Reassurance that it is common and usually responds to conservative simple measures; but symptoms can recur from time to time
3. Application of heat to the side of the face (e.g. heat pad or hot water bottle). This can be combined with simple massage techniques to the tender muscle areas and relaxation techniques.
4. Advice concerning the use of pain killers. NSAIDS' e.g. ibuprofen are often helpful, unless contraindicated due to the patients' medical history. These should be taken regularly for two to three weeks as opposed to PRN. NSAID gel can be applied topically to the area of the joint of muscles of mastication externally.
5. The identification and avoidance of parafunctional habits such as clenching or grinding, nail biting, lip/cheek biting and posturing the jaw.
6. Rest for the TMJ, including soft diet, especially if there are acute phases.
7. Acknowledgement that the condition can be related to anxiety and stressful events.
8. Provision of a soft occlusal splint which can be work at night, this is particularly useful for those with nocturnal parafunction.

Indications for referral to secondary for TMJPDS patients are:

- Multiple unsuccessful treatments
- Psychological distress
- Occlusal preoccupation
- Chronic widespread pain
- Disc displacement without reduction (closed lock)

Please indicate in the referral the measures you have already undertaken. For further information see the RCS Eng guidelines on TMJ management in Primary Care (www.rcseng.ac.uk/fds/publications/clinical-guidelines/clinical_guidelines/documents/temporomandibular-disorders-guideline-2013)

Routine Extractions in Warfarinsed Patients

There are guidelines related to the removal of teeth in dental practice for patients who are on Warfarin by the British Committee for Standards in Haematology (www.bcshguidelines.com/documents/Wafarinandentalsurgery_bjh_264_2007.pdf)

Patients should be managed according to these guidelines and not referred to secondary care for "routine extractions". The guidelines stipulate that extractions can be safely carried out in primary care in the following circumstances:

- Where the INR is less than 4.0
- If the socket is packed with an appropriate haemostatic agent and sutured

Warfarin should **not** be stopped, but the INR must be checked within a 72 hour window of the procedure.

It is recommended that extractions should be timed appropriately, i.e. early in the week and preferably in the morning so that delayed re-bleeding can be managed during the working day.

Patients should be referred to secondary care if other coagulopathies co-exist, or if the INR is unstable or if they fulfil any of the criteria described in the referral guidelines.

Patients Managed on New Oral Anticoagulants

There has been much debate about patients who are medicated with new oral anticoagulants e.g. Dabigatran and Rivoroxaban.

It is recommended that these patients are referred to secondary care for management where we are able to liaise with colleagues in Haematology where appropriate.