Gloucestershire Oral & Maxillofacial Surgery Service

Minor Oral Surgery Referrals – 2018 Guidelines

Summary Sheet & FAQs

Full details at: www.gloshospitals.nhs.uk/glosmaxfax

All practitioners must use the latest referral forms for all oral surgery, oral medicine & TMJ referrals

Referral proforma *NEW 2018 Forms now live*

www.gloshospitals.nhs.uk/glosmaxfax/referrals

Procedure / condition specific proforma exist for

- Third molar surgery
- Routine dento-alveolar surgery
- Temporo-mandibular disorders
- Oral medicine & intra-oral soft tissue lesions
- 2 Week Wait suspected oral / head & neck cancer

PDF & Word versions are available.

Please note:

- **Please only use the latest Gloucestershire Hospitals NHS Trust proforma. Other providers' forms will be rejected.**

- **Failure to complete all sections of the referral will result in the return of the referral and subsequent delay in the patient's treatment.**

- **Failure to submit a satisfactory radiograph, if appropriate, will result in the return of the referral and subsequent delay in the patient's treatment.**

- **Failure to submit an up to date medical history with details of all current medication will result in the return of the referral and subsequent delay in the patient's treatment.**

- **It is rare for a patient's medical history to complicate the extraction to such an extent that it needs to take place within the hospital setting (see later sections).**

Anxiety Management

www.gloshospitals.nhs.uk/glosmaxfax/sedation

Over the past 15 years there has been a welcome change in the provision of anxiety management for dentistry in the UK. This has resulted in an increased emphasis on the safe provision of conscious sedation instead of a reliance on general anaesthesia that is demand-led.

Conscious sedation is provided in a number of dental practices in Gloucestershire.

Where to refer?

Routine dental extractions & retained roots

- Adult patients should be referred to a **primary care provider** of conscious sedation.
- Children may also be referred to a **primary care provider** of paediatric conscious sedation or to '**Gloucestershire Care Services Dental Clinic'** at Southgate Moorings, Gloucester.

Complex dento-alveolar / third molar cases will be accepted by our department.

The provision of General Anaesthesia for these patients is out-dated and carries an increased level of risk especially as safer, less interventive and equally acceptable conscious sedation methods exist.

The default position is that anxious patients will be offered conscious sedation – please DO NOT offer GA

Radiographic Image Transfer

www.gloshospitals.nhs.uk/glosmaxfax/xrays

From publication of these guidelines we will only accept radiographic images that comply with the detail described via the above link. Please ensure your patients receive prompt care by complying fully with the above.

Requests for extractions and apicectomy will **only be accepted** if accompanied by a recent, good quality and appropriate radiograph:

- Peri-apical images for extractions and apicectomy. ('Bite-wings' not acceptable)
- OPT for third molar assessment / extractions.

If you do not have an OPT facility then please arrange for one to be recorded at a neighbouring practice or contact the radiology department at GRH / CGH and request an appointment there for an OPT in advance of the patient's assessment appointment.

We cannot accept radiographs by email at the present time (non-secure email).

Medical Conditions

Very few patients have medical conditions that necessitate extractions in a secondary care environment. A wealth of advice is available on the internet from several national bodies on how to manage these patients. We do not have any departmental policies on this subject – we simply follow national guidance and would recommend these to you.

Bisphosphonates & anti-resorptive medicines

www.gloshospitals.nhs.uk/glosmaxfax/mronj

Current guidance would suggest that those taking the oral version of these medicines for management of osteoporosis can be safely managed in dental primary care as the risk of BRONJ / MRONJ is very low. Higher-risk groups (IV preparations) may also be suitable for primary dental care.

Excellent advice is available from the following website:

www.sdcep.org.uk/published-guidance/bisphosphonates/

Anti-coagulant medication

www.gloshospitals.nhs.uk/glosmaxfax/anticoagulants

Most patients who are prescribed anti-coagulant medication can be safely managed in dental primary care.

Warfarinised patients

Straightforward extractions can be carried out in dental primary care so long as the INR is <4.0 within 24 hours of the planned extraction. Liaise with patients GP regarding timing of INR. Surgicel and a suture/s should be placed.

No patient should have an INR >4. If it is, then defer extraction until INR <4. Liaise with GP.

NOACs (dabigatran, apixaban & rivaroxaban)

These drugs are not monitored in the same way as Warfarin and have a short half-life. Straightforward extractions can be carried out in dental primary care. Give consideration to stopping the drug for 1 day prior to extraction **with the agreement of the patient's GP**. Again Surgicel and a suture should be placed.

Excellent advice is available from the following website:

www.sdcep.org.uk/published-guidance/anticoagulants-and-antiplatelets/

Non-Third Molar Extractions & Retained Roots

NHS England has identified the inappropriate referral of extractions that should be carried out in practice as an area where improvements are necessary.
As part of their GDS contract NHS providers and performers are expected to carry out extractions of teeth including the removal of retained roots in the referring practitioners' dental surgery under local anaesthetic.

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 / primary care** by another, more experienced performer.

The patient should **only be referred** if they present with special difficulties and lie outside the competence of the dentist concerned, for example:

- Associated pathology that needs to be submitted for histological examination (e.g. cysts).
- 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 these guidelines the referring dentist must justify the reasons why the treatment cannot be undertaken by them in primary dental care.

Please ensure that relevant radiographs accompany all requests (as detailed above) so that unnecessary additional radiation exposure to patients is avoided.

If additional restorative dentistry is being planned as part of the patients existing treatment plan, this treatment **must** be continued by the referring dentist while the patient is awaiting specialist assessment and treatment. Please also indicate on the referral form which additional teeth are planned to be restored and do not also need to be considered for extraction.

Management of Third Molars

In general, symptom and sign-free third molars do not require removal. Anterior crowding alone is not an indication for wisdom teeth removal in the absence of a specialist orthodontic opinion.

The National Institute for Health and Care Excellence (www.nice.org.uk) has published guidance that indicates who stands to benefit (and when) from having their third molars removed. We follow these guidelines locally and encourage referrals when these criteria for referral are met. In many cases these teeth may be removed in primary dental care.

Referral to a specialist may be necessary where anatomical or pathology considerations make the extraction difficult, where the patient has medical complications, where the operator does not have the relevant training or experience, or where previous attempts at extraction have failed.

The wisdom tooth / teeth to be removed must fulfil at least one of the following criteria:

- Recurrent episodes of pericoronitis.
- Single severe episode of pericoronitis which showed evidence of spread and infection to facial tissues.
- Caries not amenable to restoration.
- Wisdom tooth contributing to caries or periodontal disease of second molar.
- Associated follicular cystic changes.
- Periapical pathology.
- Prior to orthognathic surgery.
- Associated with cyst or tumour.
- Prior to medical treatment that would increase risk e.g. radiotherapy, IV bisphosphonates or chemotherapy.

Further Information

NICE Guidance: www.nice.org.uk/Guidance/TA1

Apicectomy / Surgical Endodontics

www.gloshospitals.nhs.uk/glosmaxfax/apicectomy

Orthograde root canal therapy is the first treatment option to treat periapical pathology.

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. Significant cyst formation (>5 mm on radiograph) is an indication for apicectomy and establishment of diagnosis.

In order to prevent recontamination and failure of apical surgery all patients **must** have a satisfactory coronal seal.

We will accept referrals for apicectomy to upper incisors and canines that meet the above criteria. Upper premolars will only be considered in exceptional cases. The success rate of apical surgery on molar teeth and lower teeth is low and will not be undertaken here.

Further guidance:

www.rcseng.ac.uk/dental-faculties/fds/publications-guidelines/clinical-guidelines/

Temporo-mandibular Disorders

www.gloshospitals.nhs.uk/glosmaxfax/tmj

The majority of patients with TMJ problems will be suffering from TMPDS (Temporo-mandibular pain dysfunction syndrome) / myofascial pain. **In most instances these patients can be managed well in dental primary care without the need for referral.**

The most common symptoms are:

- **Pain** – usually a dull ache in and around the ear. The pain may radiate along the cheekbone and downwards into the neck
- **Joint noise** – such as clicking, cracking, crunching, grating or popping
- **Limited mouth opening**
- **Headache**, especially in the temporal region
- Some patients report mild/transient **facial swelling** which may be worse in the morning

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

The following initial management advice can be provided in dental primary care

- Explanation of the condition and provision of relevant patient leaflet.
- Reassurance that TMPDS is not serious and that it usually responds to simple measures. Symptoms may recur from time to time.
- Application of heat to the side of the face, e.g. a warm hot water bottle wrapped in a towel applied to the side of the face. This can be combined with simple massage to the tender muscle areas and relaxation techniques.
- Advice concerning the use of painkillers. Non-steroidal anti-inflammatory drugs (NSAIDs), e.g. ibuprofen, are often helpful. These should be taken regularly for a two to three week period, not just PRN. NSAID gel can be applied topically to the area over the joint or the muscles of mastication.
- The identification and avoidance of parafunctional habits, such as clenching or grinding (particularly at night), nail-biting, lip/cheek biting and posturing of the jaw.
- Rest for the TMJ, including soft diet, particularly if there are acute phases.
- Provision of a soft lower occlusal splint, which can be worn at night – this is particularly useful for patients who grind their teeth at night.

NB: Irreversible procedures such as occlusal adjustment should only be undertaken if there is a clear indication.

Patients who should be referred for management in secondary care:

- Diagnostic doubt / atypical presentation (e.g. numbness of the face, marked/persistent facial swelling, severe trismus which is unrelated to surgical intervention or injury).
- Patients who fail to respond to conservative measures, including the provision of a soft splint with persistent trismus at 3 months or intractable pain at 3 months.

Oral Medicine

Oral medicine involves specialist care of patients with symptoms arising from the mouth that often do not relate directly to teeth and where management is not primarily surgical. The symptoms are often chronic and may have significant psychological as well as physical impact on the patient's quality of life.

The Oral & Maxillofacial Surgery department will provide diagnostic assessment with subsequent advice and management for soft tissue disease of the mouth and jaws, chronic facial pain, and the oral manifestation of systemic disease. These systemic medical conditions may include diseases of the gastrointestinal tract, rheumatological and haematological conditions and immunological disorders.

Conditions to be referred for diagnosis & initial treatment

- Ulceration lasting more than two weeks **(see Oral Cancer below)**
- Recurrent oral ulceration
- Blistering conditions of the oro-facial region and oral mucosa
- White or red patches of the oral mucosa (including lichen planus)
- Pigmented conditions of the oral mucosa (consider x-ray for amalgam tattoo)
- Oro-facial pain of non-dental origin (burning mouth syndrome, trigeminal neuralgia and unexplained oro-facial pain
- Other altered oro-facial sensations
- Soft tissue swelling of the oro-facial region
- Oro-facial manifestations of systemic disease
- Candidiasis or angular cheilitis (although suitable for primary care management)
- Dry mouth and other symptoms related to salivary glands (although please consider medication as a potential cause)

Please refer these patients using our 'Oral Medicine & Intra-oral Soft Tissue' form which includes a 'mouth map' for accurate localisation / description of the area in question.

Oral and Head & Neck Cancer

Patients with abnormal areas or lesions in the mouth / on the face that are suspected of being oral and / or head & neck cancer must be referred for an **urgent** Oral & Maxillofacial Consultation.

The 2 week wait suspected oral and head & neck cancer referral form must be completed and faxed within 24 hours directly to the Oral & Maxillofacial Surgery Booking Service as detailed below. It is advisable to check the referral has been received.

All suspected cancer referrals are subject to the "Two Week Wait" cancer waiting times.

Warning signs of oral cancer are:

- Non-healing, often painless ulcer or sore for more than three weeks.
- Lump or thickness in the cheek or elsewhere in the mouth.
- Persistent soreness of the throat or mouth.
- Difficulty chewing or swallowing.
- Numbness of the tongue or other areas of the mouth.
- Swelling of the jaw which causes the dentures to fit poorly.
- Loosening of the teeth or pain around the teeth or jaw.
- Voice changes.
- A lump or mass in the neck.
- Weight loss.

Examination of the oral soft and hard tissues should be performed in line with NICE dental recall guidelines. Dental practitioners should be aware of the most common appearance, warning signs and symptoms of oral cancer. We provide lectures for GDPs through the local BDA group.

Preventive advice concerning tobacco cessation, reduction of excessive alcohol consumption and healthy eating habits should be offered.

Suspected Oral & Head / Neck Cancers should be referred without delay using the "Head & Neck Cancer" referral proforma (link below)

www.gloshospitals.nhs.uk/en/Staff-and-Healthcare-Professionals/Choose-and-Book/Referral-Forms/

GDPs: Please use the "2WW Head & Neck – Generic Form"

Fax to 0300 422 5994 / 5995 & confirm receipt by phone, 0300 422 6940

Frequently Asked Questions

"When should I refer an extraction?"

As part of their GDS 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. Please look through the guidelines carefully. NHS England has identified the inappropriate 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.

"What should I send?"

- Completed condition-specific referral form (see website)
- An *accompanying* typed letter will be acceptable in addition
- Full medical & drug history
- Good quality x-ray (see website for acceptable formats)

"Where should I send the referral form?"

Referrals that meet the above criteria should be sent to:

Oral & Maxillofacial Surgery Referrals
Central Booking Office
Victoria Warehouse
The Docks
Gloucester
GL1 2EL

Tel: 0300 422 6940

Fax: 0300 422 5994 / 5995

"How should I refer a suspected cancer case?"

A suspected cancer case should be referred without delay using the "2 week wait suspected Head & Neck Cancer proforma".

These should be faxed as above immediately and a follow-up phone call made to confirm receipt.

"How can I improve my extraction skills?"

The South-West dental post-graduate office offers a range of courses for interested GDPs.
www.dental.southwest.hee.nhs.uk/

What happens if I encounter problems and am unable to complete a surgical procedure?"

Firstly you should ask a colleague in your practice to assist but if that is not possible then you can ring for advice.
Gloucestershire Hospitals NHS Foundation Trust – 0300 422 2222
Please ask to speak to the “maxillofacial SHO on-call”

"What will happen if a referral is rejected?"

A referral will only be returned to the referring practitioner after a clinician has reviewed it. The referring practitioner will be sent a letter stating the reason for the rejection and the patient will also be informed. It is then up to the practitioner to provide more details of why the referral is appropriate, undertake the procedure in practice or seek an alternative primary care provider.

"Will I get my radiographs back?"

We are aware that radiographs have not always been returned in the past but in future every effort will be made to return original radiographs with correspondence. Digital radiographs should be printed on good quality photographic paper.