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Referral Criteria for acceptance for Dentoalveolar Surgery –Hard Tissue

This document has been written to support practitioners in understanding the referral criteria for acceptance of MOS dentoalveolar- hard tissue surgery.

Contract holders of mandatory service contracts are required to ensure that all clinicians providing care under the mandatory service contract are:-

a) competent to provide a quality referral which includes x-rays to make an accurate diagnosis
b) competent and have the skills to undertake extractions/removal of teeth as noted in the mandatory service contract
c) equipped with a range of dental equipment (forceps etc) to undertake extractions and removal of roots as required by the General Dental Services contract or ensure there are arrangements within the practice to support practitioners who are unable to provide such treatment
d) knowledgeable of NICE guidelines, other national guidelines as well as other best practice
e) able to provide on-going care to the patient following referral (e.g. acute problems whilst patient waiting for an appointment) and discharge (e.g. treatment for dry socket)

Patients who have a dental phobia and who cannot be treated within a GDS practice for removal of teeth under mandatory services can be referred to an anxiety management/sedation clinic.

For patients with learning disabilities, unstable mental health problems or dementia that are untreatable within the dental chair and would benefit from the provision of not only extractions but also full oral examination, radiographs and conservation under General Anaesthetic, please continue to refer directly to the Special Care Dentistry service.

A treatment plan may require several extractions/removal of teeth – referrals will only be accepted for treatment for each tooth/teeth meeting the acceptance criteria. When making a referral:-

a) patients must be informed of the referral being made, and the name of both the preferred primary care provider and secondary care provided must be noted on the referral form
b) patients must be informed of the treatment requiring referral i.e. treatment for each tooth
c) it is important to discuss with the patient the options/differential diagnosis for treatment a alternative treatment, different to the referral, may be considered by the specialists in Ora Surgery

Please note clinicians can undertake MOS treatment under the mandatory service contract and are encouraged to do so. Many practices would have undertaken MOS treatment under the NHS contract prior to 2006- contract values included previous wide ranging activity.

The Minor Oral Surgery specialists will assess all referrals for dentoalveolar surgery and refer patients onwards for patients requiring treatment beyond the competency of an MOS specialist or patients requiring sedation or GA services
The specialist MOS providers welcome queries regarding MOS treatment.

Thank you for your co-operation

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Acceptance criteria for Minor Oral Surgery
dentoalveolar –hard tissue procedures

The following procedures are accepted for specialist MOS dentoalveolar surgery. All referred treatment will be assessed by the primary MOS providers. Accepted for treatment will be undertaken in primary care or secondary depending on the appropriateness of setting and competency of the MOS primary care specialist provider.

Accepted treatment

- Unsuccessful attempt at extraction by referring practitioner- this should be a rare reason for referral
- Severely abnormal root morphology likely to compromise ease of extraction
- Root fragments situated in bone and difficult to remove by simple elevation or with root forceps. Roots in close proximity to anatomical features such as mental foramen, maxillary sinus
- Wisdom teeth meeting NICE criteria that are impacted requiring a flap procedure and bone removal and or surgical division
  (Please reference *1.2 Referral Criteria for Wisdom tooth removal)*
- Impacted or unerupted teeth that require removal as part of an orthodontic treatment plan
- Exposure and bonding of teeth as part of orthodontic treatment- patients must bring gold chains with them for treatment
- Teeth with significant cystic/ periapical areas that require enucleation
- Teeth with areas of unexplained root resorption
- Patients requiring treatment under sedation/GA- MOS specialists will decide whether patients require onward referral for sedation services or GA
- Patients on warfarin with unstable INR or INR >4 *(please reference 'Referral Criteria for Medically Compromised Patients Requiring Non-Mandatory Services')*
- Patients at high risk of developing Bisphosphonate-related Osteonecrosis of the Jaw *(please reference '1.4 Referral Criteria for Medically Compromised Patients Requiring Non-Mandatory Services')*
- Patients who are medically compromised *(please reference '1.4 Referral Criteria for Medically Compromised Patients Requiring Non-Mandatory Services')*
- TMJ dysfunction *(please reference '1.1 Referral Criteria for TMJ Dysfunction')*
- Apicectomy *(please reference '1.3 Referral Criteria for Apicectomies')*

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Rejected- Treatment to be undertaken by GDPs

- Any tooth root filled or not, with sufficient crown or roots to apply either forceps or elevators/luxators
- Single rooted teeth and multi rooted teeth whether root filled or not, that do not need division that could be elevated and removed with root forceps.
- Root fragments situated wholly in soft tissue
- Upper 8s fully erupted with good vision and access
- Lower 8s with favourable roots that are fully erupted or have > ¾ crown visible
- Wisdom teeth removal requiring flap procedure only without removal of bone.
- Extractions on patients on Warfarin with a stable INR < 4
- Patients at low risk of developing Bisphosphonate-related Osteonecrosis of the Jaw i.e. patient is about to start bisphosphonates or patients taking bisphosphonate to prevent or manage osteoporosis - these patients can be treated in GDS. Atraumatic removal of teeth will provide a favourable outcome- and healing needs to be reviewed after 4 weeks.

1.1 Referral Criteria for TMJ Dysfunction

Conservative management for TMJ dysfunction –patients must have at least two of the following: - a) Pain b) Clicking/Grating/Grinding c) Restricted mouth opening/closing. Limited opening in isolation may not be indicative of TMJ dysfunction and early underlying systemic or overt joint diseases should be identified and addressed.

TMJ dysfunction is frequently self-limiting, and conservative treatment including drug therapy and counselling are effective for 70% of patients. The initial management for patients in primary care (this could undertaken by a GDP if trained) with episodic signs and symptoms, may involve:-

- Supportive patient education such as encouraging relaxation, education against behaviours such as clenching and grinding, and recommending a softer diet
- Pharmacological pain control such as NSAID's (where this is not contraindicated)
- Recommending remedial jaw exercises

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1.2 Referral Criteria for Wisdom tooth removal

Accepted for MOS for teeth meeting NICE guidelines
Wisdom teeth meeting NICE criteria that are impacted requiring a flap procedure and bone removal and or surgical division i.e. wisdom teeth which cannot be removed by forceps or through simple elevation

- Untreatable tooth decay
- Abcesses
- Cysts or tumours- *onward referral to Maxfax unit/Secondary care
- Diseases of the tissues around the tooth
- If the tissue is in the way of other surgery

Rejected - Treatment to be undertaken by GDPs
- Impacted wisdom teeth free from disease

1.3 Referral Criteria for Apicectomies
Within primary care, conventional root canal treatment should be the first treatment option for cases with periapical pathology. If unsuccessful, non surgical re-treatment should be the preferred option for endodontic failure. Apicectomies cannot be performed without an adequate orthograde root filling.

Accepted
- Unsuccessful conventional endodontic treatment on incisor, canine or premolar tooth where there is evidence of re-root treatment, and an adequate coronal seal. The roots should show successful and complete obturation i.e. close to the apex the apex with good lateral condensation and no evidence of coronal leakage.
- Unsuccessful conventional root canal treatment due to sclerosed or obstructed canal
- Teeth with post crown and no evidence of orthograde root filling
- Patients must have caries removed prior to acceptance for Apicectomy
- Peri-radicular disease where iatrogenic (e.g. broken file) or developmental anomalies (e.g. aberrant root anatomy) prevent non-surgical root canal treatment being undertaken
- Where a biopsy or peri-radicular tissue is required (persistent cyst or inflammation which does not resolve after adequate RCT)
- Where perforation, root crack or fracture is suspected and requires visualised repair
- Where tooth sectioning or root amputation are required
- Where it may not be expedient to undertake prolonged non-surgical root canal re-treatment because of patient considerations
- Where a biopsy of a periradicular tissue is required

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Rejected- Treatment to be undertaken by GDPs

- Repeat apicectomy
- If the tooth is unrestorable
- Where the root canal therapy is inadequately obturated
- Where patients have unstable and active periodontal disease i.e. where there is poor supporting tissue
- Uncontrolled dental caries
- Where the tooth has inadequate coronal tooth tissue to support a conventional crown or other restorations
- Where the tooth has not previously been restored
- In the presence of subgingival caries or where coronal tissue has been lost to such an extent there is access to the root canal system which cannot be sealed i.e. where coronal leakage is present
- Teeth with a post crown where the post is proportionally inadequately designed.
- Teeth which have post crowns where the post does not fit the canal, or the post has been re-cemented on several occasions
- Teeth with lack of surgical access
- Patient factors –includes severe systemic disease and psychological considerations
- Possible involvement of the neurovascular bundle or maxillary antrum or other anatomical features which compromise success of treatment

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1.4 Referral Criteria for Medically Compromised Patients Requiring Non-Mandatory Services (i.e. those not covered under a primary care dental contract)

Accepted criteria for oral surgery treatment within a hospital setting would include:

- Unstable cardiovascular disease
- Respiratory function decreased to the extent the patient has to have home oxygen therapy
- Unstable epilepsy
- Any medical condition such as liver/ kidney disease that requires additional investigations prior to extraction
- Patients with coagulation disorders such as Haemophilia, Von Willebrands
- Patients on Warfarin whose therapeutic INR >4, or whose INR is unstable or requires multiple extractions
- Patients undergoing chemotherapy
- Patients who have had radiotherapy to the head and neck
- Steroid medication >10mg of prednisolone or equivalent dose of other steroid, as per BNF, in the last three months
- Patients at higher risk of developing Bisphosphonate-related Osteonecrosis of the Jaw (BONJ) are those with a previous diagnosis of BONJ, taking bisposphonate as part of the management of a malignant condition, other non-malignant systemic condition affecting bone (e.g. Paget's disease), under the care of a specialist for a rare medical condition (e.g. osteogenesis imperfecta), concurrent use of systemic corticosteroids or other immunosuppressants, coagulopathy, chemotherapy or radiotherapy
- Patients who have severe immune dysfunction
- Angina at rest
- MI<6 months ago

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Accepted in Primary Care MOS practice

- Patients on antiplatelet drugs such as aspirin, clopidogrel are at risk of excessive bleeding and therefore can be treated by a specialist in primary care (not necessarily one appointment) with liaison with the GP and will require sockets packed with a haemostat and sockets sutured.
- Patients taking Bisphosphonates and at low risk of developing BONJ only, these patients can be treated in GDS especially where the treatment will be traumatic i.e. requiring raising of a flap and removal of bone

Rejected- Treatment to be undertaken by GDPs

- Most patients with cardiovascular, respiratory disease, diabetes and epilepsy are well controlled on their medication and can be treated within the primary care setting.

- Steroid therapy maintained at <7.5mg may not need steroid cover. Available evidence suggests supplementation is unnecessary for Local Anaesthetic procedures.

- Patients on warfarin can be treated by a GDP if their INR is < 4. (an extraction appointment should be arranged 72hrs after pt has attended INR clinic to ensure INR<4). Patients should have socket/s packed with a haemostat (Surgicel) and the socket/s sutured following extraction/s surgery. The patient's GP must be consulted for the prescribing of 5% tranexamic acid mouthwash for the patient post extraction used four times a day for 2 days. As with all extractions and even more importantly with patients taking anticoagulants, it is recommended that a written instruction sheet with a telephone number for out of hours advice is given to the patient in case of bleeding. Patients taking warfarin should be prescribed non-selective NSAIDS and COX-2 inhibitors as analgesia following extraction/s

- Ideally extraction appointments will be arranged the day after a visit to the INR clinic when a reading can be obtained and brought by the patient to the appointment.

- Patients taking Bisphosphonates and at low risk of developing BONJ only, these patients can be treated in GDS especially where the extraction is atraumatic. Patients at low risk of developing Bisphosphonate-related Osteonecrosis of the Jaw i.e. patient is about to start bisphosphonates or patients taking bisphosphonate to prevent or manage osteoporosis - these patients can be treated in GDS. Atraumatic removal of teeth will provide a favourable outcome- and healing needs to be reviewed after 4 weeks

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