QUEENSWAY TEESSIDE ORAL SURGERY SERVICE (QTOSS)

Queensway Dental Practice, 170 Queensway,
Billingham, Cleveland, TS232NT

CONTENTS

Queensway Teesside Oral Surgery Service (QTOSS)

Recently, waiting times for the removal of third molar teeth and other routine **surgical** procedures in hospital departments have been increasing. In order to reduce waiting times for patients, a primary care based Specialist Oral Surgery Service has been developed for Teesside residents. Many routine surgical procedures can be safely carried out in a primary care environment.

This service will be complementary to the Hospital service and has been developed in conjunction with local Oral Surgery departments and is designed to complement the services they provide.

Clinical Criteria for referral into QTOSS

The primary care based service will provide treatment for the following clinical conditions:

- Extractions of special difficulty with associated pathology (such as ankylosis) for single and multi-rooted erupted teeth. Routine extractions will not be undertaken by this service (Appendix 1:1)

- Removal of wisdom teeth as indicated by NICE (*www*.nice.org.uk March 2000, revised 26.4.04)

- Removal of buried roots and fractured or residual root fragments

- Removal of simple impacted/ectopic/supernumerary teeth

- Exposure of teeth (removal of gum and or bone over the surface of the tooth preventing eruption) in conjunction with an orthodontic treatment plan

- Minor soft tissue surgery including:
    - Removal of simple fibro-epithelial polyps
    - Removal of simple mucoceles
    - Removal of denture induced hyperplasia (with no sinister features)

- Surgical endodontics on single rooted anterior teeth which have a satisfactory orthograde root filling in place, as indicated by a pre-operative periapical radiograph, and have apical pathology associated with them which has not diminished following root canal therapy (RCT) or is not amenable to repeated RCT (Appendix 2)

- Removal or enucleation of a simple dental cysts.

Patient Selection

The service is for:

- All Teesside patients with permanent teeth referred by their primary care dental or medical practitioners.
- Patients who are healthy or have mild systemic disease with no functional limitation - for example, ASA I and ASA II .
- Warfarinised patients can usually be managed in general dental practice and would not routinely be accepted by this service (Appendix 3), unless the treatment required met the above clinical criteria.
- Patients requiring oral surgery treatment under local analgesia alone or in conjunction with conscious sedation. Treatment under general anaesthesia will not be provided by this service.

All patients who fit these criteria should be referred to the Queensway primary care service in the first instance.

Patients requiring more complex oral surgery treatment that do not meet the above described clinical criteria, or those being referred for care due to a complex medical history should be referred to a secondary care setting.

Patients with suspicious white/red patches (suspected cancer referrals) should be referred directly to the Acute Trust. This referral should be made via the 2 week rule system.

Patients will be assessed following referral from their general dental or medical practitioner. Patients, who meet the criteria for treatment in the primary care based service, will be offered an appointment. Patients who do not meet the criteria specified above may be either referred on to secondary care or returned to the referring practitioner. The referral pathway is represented diagrammatically in Appendix 6. Referral patterns will be audited and may lead to individual discussion.

Please help the service to improve the care for your patients by providing a full assessment of the patient's needs and including details about:

- Relevant medical history e.g. prescription drugs, heart disease
- Relevant social history e.g. lives on own, does not have own transport.
- Full description of the patient's clinical condition and reason for referral
- Please ensure that relevant radiographs accompany all requests to avoid unnecessary radiation exposure to patients. These radiographs will be returned once treatment has been completed.

HOW TO REFER

The referral form for referral of minor oral surgery cases to Queensway can be found in on page 23.

All referrals to Queensway must have a referral form, which can either be faxed or posted.

Urgent referrals can telephoned through to Queensway, but will need to be followed through with a referral form.

Please advise the patient you are making the referral to the service and the patient should expect to be contacted for arrangement of an assessment appointment.

CONTACT DETAILS

The address to refer to Queensway Teesside Oral Surgery Service (QTOSS) is:

QTOSS

Queensway Dental Practice

170 Queensway

Billingham

Cleveland

TS23 2NT

Tel01642554667 Fax 01642531799 e-mail dental @Queensway.co.uk

If you require further information please contact Uzma Mansoor, Paul Averley, Ian Lane or Matt Dorman on 01642 554667. You can also obtain information on the Queensway website: www.queensway.co.uk

OTHER ORAL SURGERY REFERRAL SERVICES

Referrals in to the hospital acute trust should be made in cases where patients require more complex treatment than the clinical categories listed in the referral guidelines or where complex medical conditions require treatment in hospital (e.g heamophilia, bleeding disorders etc).

2-Week Rule Referrals:

In cases where red or white patches need urgent investigation immediate referral should be made to the Acute Trust using the 2–week rule protocols. These patients should not be given the choice of referral into primary care, as time is an important factor in their care.

Urgent referrals:

There is a 24 hour on-call service at James Cook University Hospital for urgent referrals such as:

- facial fractures
- uncontrolled oral bleeding
- orofacial infections producing swelling, trismus or airway problems

To make enquiries to this service please telephone James Cook University Hospital on 01642 850850 and ask for the on call oral & maxillofacial SHO. Do NOT give the patient a letter and ask them attend the department or Accident & Emergency without having spoken to the department.

Appendix 1: Non-third molar exodontia

The service does not provide a service for "routine" extractions in healthy patients.

If a surgical approach is obviously necessary (e.g. retained roots, ankylosis, etc) then referral should be made.

Indications for referral include:

Associated pathology that needs to be submitted for histological examination (e.g. cysts).

It is rare for a patient’s medical history to complicate the extraction to such an extent that it needs to take place within a specialist setting. If the reason for referral is a medical reason, the referral needs to be made to a hospital setting.

Please ensure that relevant radiographs accompany all requests to avoid unnecessary radiation exposure to patients. These radiographs will be returned once treatment has been completed.

Appendix 2: Guidelines for Peri-apical Surgery

All teeth should be adequately root filled prior to referral, repeat root filling has a higher success rate than apicectomy and hence should be carried out. The success rate for re-apicectomy is very low and will not be carried out by the primary care service. The service will not accept referrals for apicectomies on multi rooted teeth. Practitioners should undertake a full clinical assessment of their patient and provide the service with written details giving the clinical justification for the requirement to have an apicectomy. See Appendix 1 for more detail.

More comprehensive guidelines for referral for apicectomy are available at www.rcseng.ac.uk/dental/fds/clinical_guidelines.

Although there are exceptions referrals should meet the following criteria to be accepted to undergo periapical surgery:

- Completed primary root canal treatment, whether crowned or not.
- Completed root canal **RE-TREATMENT**, particularly if the primary treatment appears radiographically sub-optimal (e.g. lack of adequate condensation or short of apex).
- Post removal should be performed to enable root canal re-treatment where risk to root structure is minimal.
- A satisfactory coronal restoration (preferably a permanent restoration) should be present to ensure good coronal seal of the root canal system.

It is generally agreed that endodontic failures are best approached non-surgically by undertaking root canal re-treatment rather than periapical surgery[1,2,3].
The success rates for apical surgery on molar teeth is low and will not routinely be undertaken.
Repeat apicetomy has a low success rate and also will not routinely be undertaken[2,8].

Queensway requests that referral to be considered for periapical surgery include **a copy or the original of the most contemporary radiograph** in relation to the teeth in question to avoid unnecessary radiation exposure to patients (these radiographs will be returned after the completion of treatment).

If a non-surgical approach is felt to be appropriate but it is not possible to meet these criteria in primary care, consideration should be given to referring the patient to an endodontic specialist.

Indications for periapical surgery – based on RCS guidelines[4]:
- in cases when it is agreed that orthograde retreatment is either impossible or will not solve the problem.

1. Failure of initial and repeat conventional orthograde RCT – which appears radiographically satisfactory.
2. Gutta percha significantly through apex and associated with periapical pathology.
3. The presence of periradicular disease in a root filled tooth, where non-surgical root canal re-treatment cannot be undertaken or has failed, or where conventional re-treatment may be detrimental to the retention of the tooth.
4. Physical barriers/anatomy – irremovable posts, fractured instruments, sclerosed canals (clinically and radiographically).
5. The presence of periradicular disease in a tooth where iatrogenic or developmental anomalies prevent non-surgical root canal treatment being undertaken.
6. The need for biopsy of the periradicular tissues – significant periapical pathology not resolving following satisfactory orthograde RCT (e.g. radiolucency greater than 1cm diameter).
7. The need to visualise the periradicular tissues and tooth root when perforation, root crack or fracture is suspected.
8. Fracture and infection of apical third (post traumatic)

Contraindications to surgical endodontics[4]

There are few absolute contraindications to endodontic surgery

1. Patient factors including presence of severe systemic disease and psychological considerations
2. Anatomical factors including:
   - Unusual bony or root configurations
   - Lack of surgical access
   - Possible involvement of the neurovascular bundle
   - Where the tooth is subsequently unrestorable
   - Were there is poor supporting tissue
3. The skill, training and experience of the operator also has an influence

Surgical Outcomes

1st apicectomy

Success rates for apicectomies range from 30% (poorly root treated and inadequately restored) – 80% (well root treated and restored teeth)[5,6]

One newer study using microscopy and MTA suggests a success rate up to 92%[7]

Comparison between 1st and 2nd apicectomies[2,8]:

Initial surgery:	Success	64.2%
	Uncertain	25.7%
	Failure	15.75%
Second surgery	Success	35.7%
	Uncertain	26.3%
	Failure	38%

References

1. Carrotte P. Surgical endodontics. Br Dent Journal 2005; 198(2): pp 71-79
2. Dummer M. H. Surgical endodontic retreatment success and failure are almost equivalent. Evidence-Based Dentistry 2003; 4: pp51
3. Guidelines for Apical Surgery, BAOMS website
4. Guidelines for Surgical Endodontics, R.C.S. Eng 2001
5. Jansson L, Sandstedt P, Laftman AC, Skogland. Relationship between apical and marginal healing in periradicular surgery. Oral Surg, Oral Med, Oral Path, Oral Rad, Endod 197; 83: 596-601
6. Rud J, Andreasen JO, Jensen JE. Radiographic criteria fr the assessment of healing after endodontic surgery. Int J Oral Surg 1972; 1: 195-214
7. Maddalone M, Gagliani M. Periapical endodontic surgery: a 3 year follow-up study. Int Endod J 2003; 36: 193-198
8. Peterson J, Gutmann JL. The outcome of endodontic resurgery: a systematic review. Int Endod 2001; 34: pp169-175

Appendix 3:

ROUTINE NON SURGICAL EXODONTIA IN WARFARINISED PATIENTS

Please do not refer to the service for routine non-surgical extraction because the patient is on warfarin.

There has been recent guidance issued related to the removal of teeth in dental practice for patients who are on warfarin (NPSA 2009). Patients should be managed according to these guidelines in general practice and not referred to the specialist services for "routine" extractions. The guidelines stipulate that extractions can safely be carried out in general practice in the following circumstances:

- Where the INR is less than 4.0.
- If the socket is packed and sutured.

Warfarin should not be stopped but the INR must be checked within 72 hours (ideally with 24 hours) of the planned extraction (patients can usually co-ordinate this themselves with either their doctor or anticoagulant clinic).

Patients should be referred to the hospital service if the patient is known to have one or more of the following:

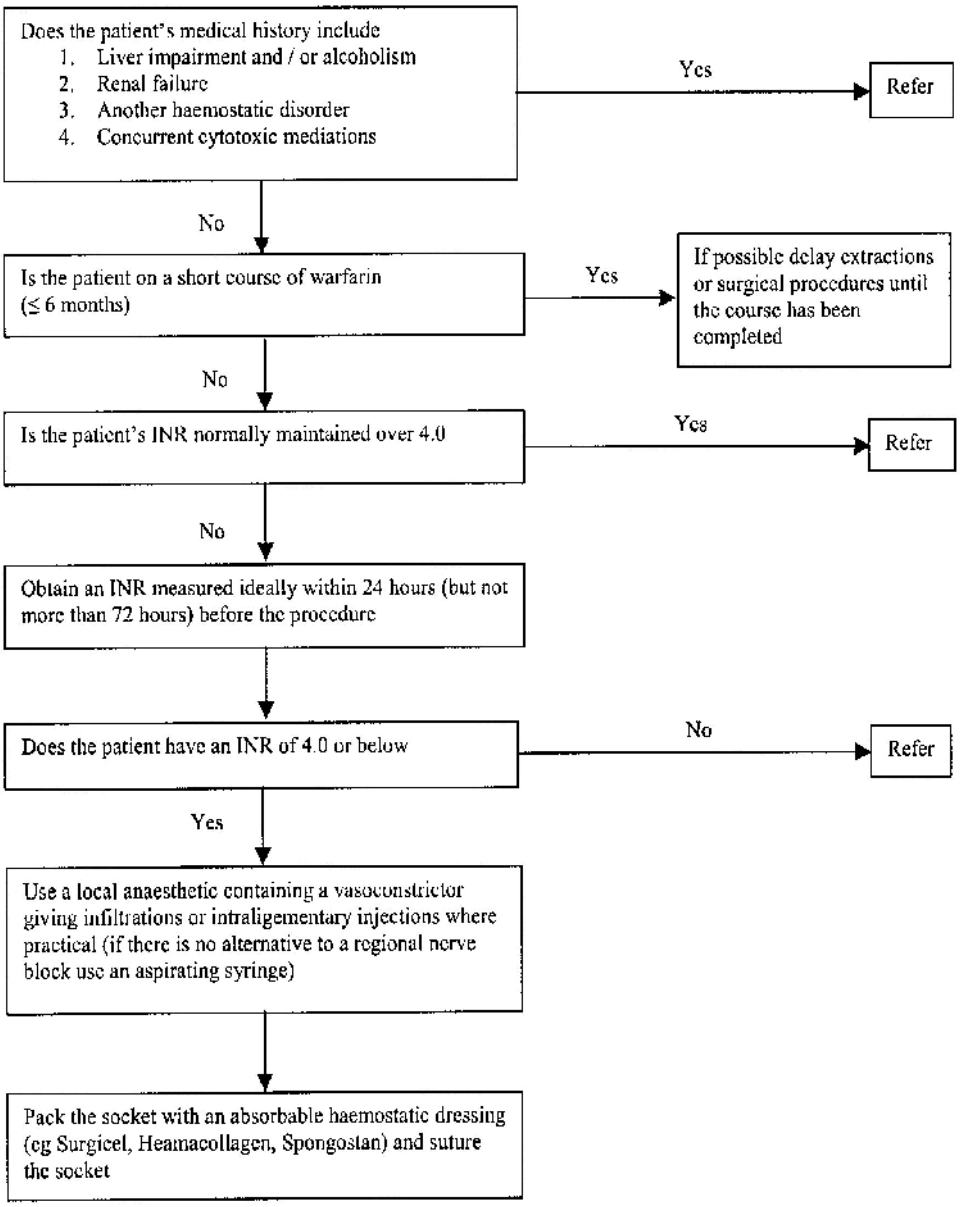
- Liver impairment/high alcohol intake
- Renal failure
- Thrombocytopenia
- Haemophilia
- Other disorders of haemostasis
- Receiving chemotherapy
- Taking more than one antiplatlet drug
- if the INR is maintained at over 4 (the latter will be recorded in the patient's anticoagulant book).

Extractions taking place in general practice should be timed appropriately and ideally should take place at the beginning of the week (such that delayed re-bleeding problems can be managed during the working week) and in the morning (such that immediate re-bleeding problems can be managed during the working day).

These guidelines are available at www.npsa.nhs.uk/nrls/alerts-and-directives/alerts/antiocoagulant/ and are summarised overleaf.

(please note, referral is into hospital if following this guideline)

Management of routine exodontia in warfarinised patients undergoing surgical procedures in primary care



If the patient requires concurrent endocarditis prophylaxis follow guidelines making note of potential drug interactions.

If the patient requires post-operative analgesia non-steroidal anti-inflammatory drugs should be avoided because of interactions.

Appendix 4: Bisphosphonate-associated Osteonecrosis of the Jaw (ONJ)

Clinician & Patient information notes

What are Bisphosphonates?
Bisphosphonates are a group of drugs mainly used for the treatment of osteoporosis (taken orally) but are also used in the treatment of cancer (given intravenously and in higher doses). These drugs affect the metabolism (turn-over) of bone. Examples of bisphosphonates include: alendronic acid, risidronate, zoledronic acid (Zometa).

What is Osteonecrosis of the Jaw (ONJ)?
ONJ is diagnoses clinically as the presence of exposed bone in maxillofacial region (upper or lower jaws) for more than 8 weeks in the absence of radiotherapy to the jaw. It is a rare condition, poorly understood, with increasing number of cases being seen and although there have been lots of publications their quality is limited

How likely is it to affect me?
Risk of ONJ for oral bisphosphantes is between 1:10,000 and 1:100,000
For high dose intravenous Bisphosphonates (cancer treatment) the risk rises to between 1:10 – 1:100

Antibiotics and ONJ
The British and American Dental Associations (BDA and ADA) found no evidence for prophylactic antibiotics after surgical procedures. They recommend the use of antibiotics should be based on the risk of an infection rather than because the patient is taking a bisphosphonate. Chlorhexidine mouth wash preoperatively and until the surgical site is fully healed may be helpful.

Should bisphosphonates be stopped before invasive dental surgery?
The BDA suggests assessing the clinical situation and discussion with the patient's physician or oncologist before stopping bisphosphonate therapy. Canadian guidelines recommend interrupting bisphosphonate for 3-6 months for non-emergency invasive dental treatment, however the half-life of bisphosphonates in the skeleton is high and evidence for this approach is only anecdotal.

Source of information:
Guidelines for bisphosphonate-associated Osteonecrosis of the Jaw – Derek Richards. Centre for Evidence-based Dentistry, Oxford UK. Evidence-Based Dentistry (2008) 9, 101-102. doi: 10.1038/sj.ebd.6400608

Please see over page for tables advising management of patients

BDA recommendations for patients taking bisphosphonates

Dental procedure	People with osteoporosis or other non malignant disease who have taken bisphosphonates for > 3years	Patients with malignancy, starting or receiving bisphosphonates
Dental regime	Regular dental visits, maintain good oral hygiene, stop smoking, limit alcohol	As before
Dental examination pre bisphosphonate therapy	**NO**. ONJ risk is low, standard dental care If not previously a regular attender – patient should attend for a dental examination with management as needed	**YES**. Before starting IV bisphosphonates for bone metastases. Invasive dental procedures, if needed should be completed and healed completely before starting therapy if the patient's condition allows. Liaise with physician/oncologist. If not possible, need careful follow-up of surgical sites
Extractions	Not contra-indicated as ONJ risk is low. Root canal treatment preferable. Atramatic extractions and careful follow-up of exposed bone are recommended	Avoid extractions if possible as increased risk of ONJ. Root treatment preferable. For periodontally affected teeth, only extract if excessive mobility and aspiration risk
Periodontal disease	Periodontal surgery is appropriate if it reduces or eliminates bone disease. Can carry out modest bone recontouring	Periodontal surgery is not recommended. Non surgical periodontal treatment only
Dentures	Well fitting required	Well fitting +/- soft lining
Endodontics	Avoid apical surgery. Conventional orthograde root filling rather than extraction if possible. Good coronal seal maintenance important	Avoid apical surgery. Conventional orthograde root filling rather than extraction if possible. Good coronal seal maintenance important
Implants	Currently not contraindicated if taking bisphosphonates but prudent to gain informed consent which should be documented (risk assessment)	Not recommended and avoid elective surgery such as tori removal

Canadian recommendations for management of patients with ONJ

Patient Groups using bisphosphonates	Recommended action by dentist
All patients	Stop smoking, limit alcohol intake, maintain good oral hygiene
Oncology patients	A thorough dental exam including radiographs should be completed before commencing IV bisphosphonates
	Any invasive dental procedure ideally to be completed prior to commencing high dose therapy
	Non-urgent procedures preferably to be delayed for 3-6 months following interruption of bisphosphonate therapy
Osteoporosis patients taking oral/intravenous bisphosphonates	Dental examination not required prior to initiating therapy if there is appropriate dental care and good oral hygiene
Individuals with established ONJ	Best managed with supportive care including pain control, treatment of secondary infection, removal of necrotic debris, and mobile sequestrate
	Aggressive debridement is contraindicated

Appendix 5: NICE guideline on prophylaxis for infective endocarditis

The National Institute for Health and Clinical Excellence (NICE) issued a clinical guideline on antibiotic prophylaxis against infective endocarditis (IE) in March 2008. In a significant change to current clinical practice, the guideline recommends that antibiotics to prevent IE should ***not*** be given to adults and children with structural cardiac defects at risk of IE who are undergoing dental and non-dental interventional procedures.

IE is an inflammation of the inner lining of the heart, particularly affecting the heart valves, caused by bacterial or other infection. It may arise following bacteraemia in patients who have certain pre-existing heart conditions (see list below). Although IE is a rare condition, with fewer than 10 people in every 100,000 developing it each year, it can be life-threatening. It has been accepted clinical practice to use preventive (prophylactic) antibiotics before dental and some non-dental procedures in people who are considered to be at risk of IE. However, the effectiveness of this treatment in humans has never been properly investigated and clinical practice has been dictated by clinical guidelines based on expert opinion.

This guideline is based on the best available published evidence and a consensus of multidisciplinary, expert opinion within the Guideline Development Group (GDG).

The guideline concludes that there is no consistent association between having an interventional procedure, dental or non-dental, and the development of IE and that the clinical effectiveness of antibiotic prophylaxis is not proven. The evidence also suggests that antibiotic prophylaxis against IE for dental procedures is not cost effective and may lead to a greater number of deaths through fatal anaphylactic reactions than not using preventive antibiotics. The guideline makes a number of key recommendations, including:

• Patients should *not* be offered antibiotics to prevent IE for any of the following procedures:

- a dental procedure
- an obstetric or gynaecological procedure, or childbirth
- a procedure on the bladder or urine system
- a procedure on the gullet, stomach or intestines
- a procedure on the airways, including ear, nose and throat and
- bronchoscopy.

• Healthcare professionals should regard people with the following cardiac conditions as being at risk of developing IE:

- acquired valvular heart disease with stenosis or regurgitation
- valve replacement
- structural congenital heart disease, including surgically corrected or palliated structural conditions, but excluding isolated atrial septal

defect, fully repaired ventricular septal defect or fully repaired patent ductus arteriosus, and closure devices that are judged to be endothelialised
- previous IE
- hypertrophic cardiomyopathy.

• Healthcare professionals should offer people at risk of IE clear and consistent information about prevention, including:
- the benefits and risks of antibiotic prophylaxis, and an explanation of why antibiotic prophylaxis is no longer routinely recommended
- the importance of maintaining good oral health
- symptoms that may indicate IE and when to seek expert advice
- the risks of undergoing invasive procedures, including non-medical procedures such as body piercing or tattooing.

• People at risk of IE who are receiving antimicrobial therapy because they are undergoing a gastrointestinal or genitourinary procedure at a site where there is a suspected infection should be offered an antibiotic that covers organisms that cause IE.
• Investigate and treat promptly any episodes of infection in people at risk of IE to reduce the risk of endocarditis developing

The full guidance is available at www.nice.org.uk/CG064

Appendix 6: THE 18-WEEK RULES SUITE - NATIONAL CLOCK RULES

Clock Starts

1. An 18-week clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:

a) a consultant led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner;

b) an interface or referral management or assessment service, which may result in an onward referral to a consultant led service before responsibility is transferred back to the referring health professional or general practitioner;

2. An 18-week clock also starts upon a self referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional.

3. Upon completion of an 18-week referral to treatment period, a new 18-week clock only starts:

a) when a patient becomes fit and ready for the second of a consultant-led bilateral procedure;

b) upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan;

c) upon a patient being re-referred in to a consultant-led; interface; or referral management or assessment service as a new referral;

d) when a decision to treat is made following a period of active monitoring;

e) when a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock

Clock Pauses

4. A clock may be paused only where a decision to admit has been made, and the patient has declined at least 2 reasonable appointment offers for admission. The clock is paused for the duration of the time between the earliest reasonable offer and the date from which the patient makes themselves available again for admission.

Clock Stops

Clock stops for treatment

5. A clock stops when:

a) First definitive treatment starts. This could be:

i. Treatment provided by an interface service;

ii. Treatment provided by a consultant-led service;

iii. Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions;

b) A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

Clock stops for 'non-treatment'

6. An 18-week clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that:

a) It is clinically appropriate to return the patient to primary care for any non consultant-led treatment in primary care;

b) A clinical decision is made to start a period of active monitoring;

c) A patient declines treatment having been offered it;

d) A clinical decision is made not to treat;

e) A patient DNAs their first appointment following the initial referral that started their 18 week clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient1.

f) A patient DNAs any other appointment and is subsequently discharged back to the care of their GP, provided that:

i) the provider can demonstrate that the appointment was clearly communicated to the patient;

ii) discharging the patient is not contrary to their best clinical interests;

iii) discharging the patient is carried out according to local, publicly available, policies on DNAs.

iv) These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

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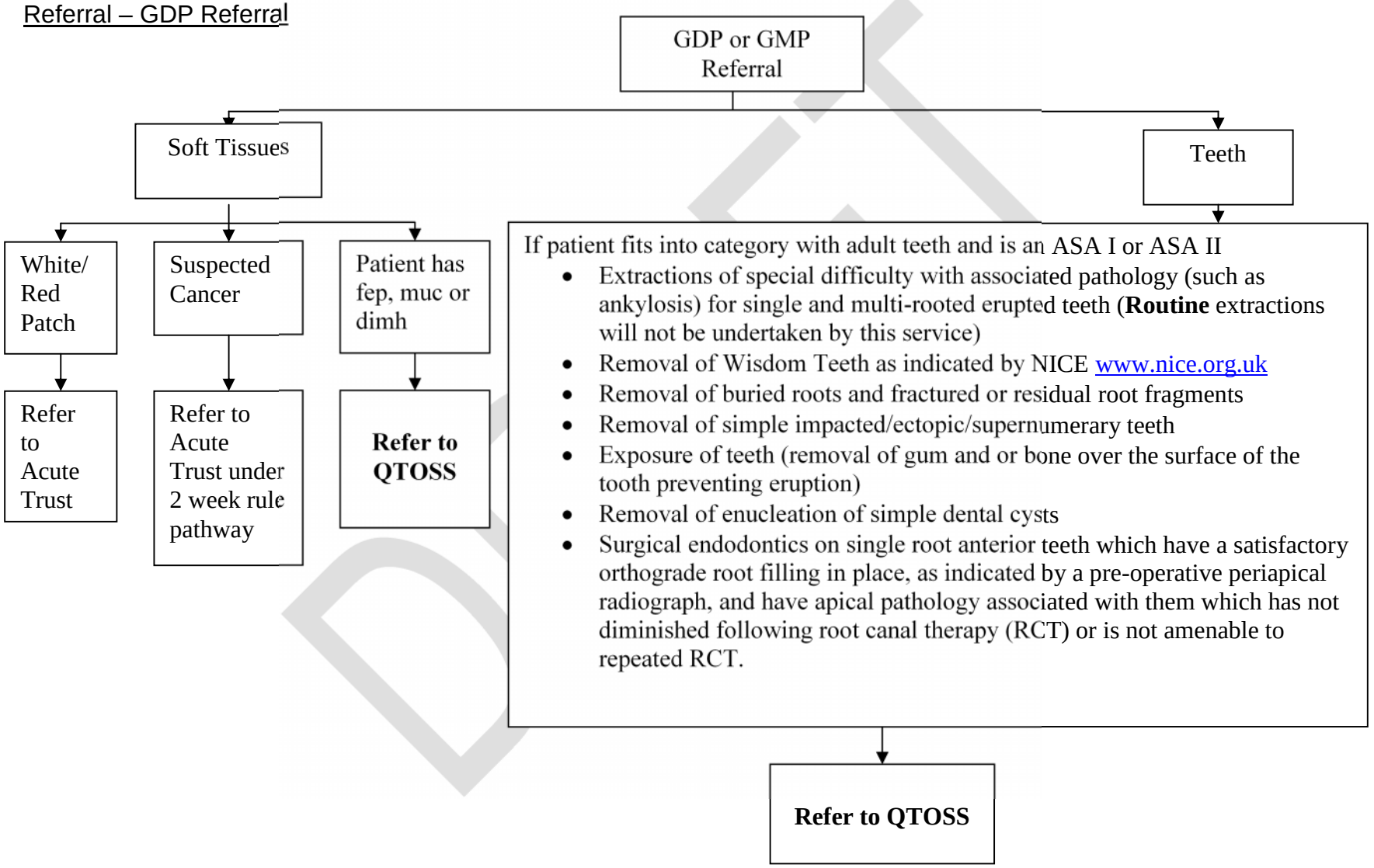
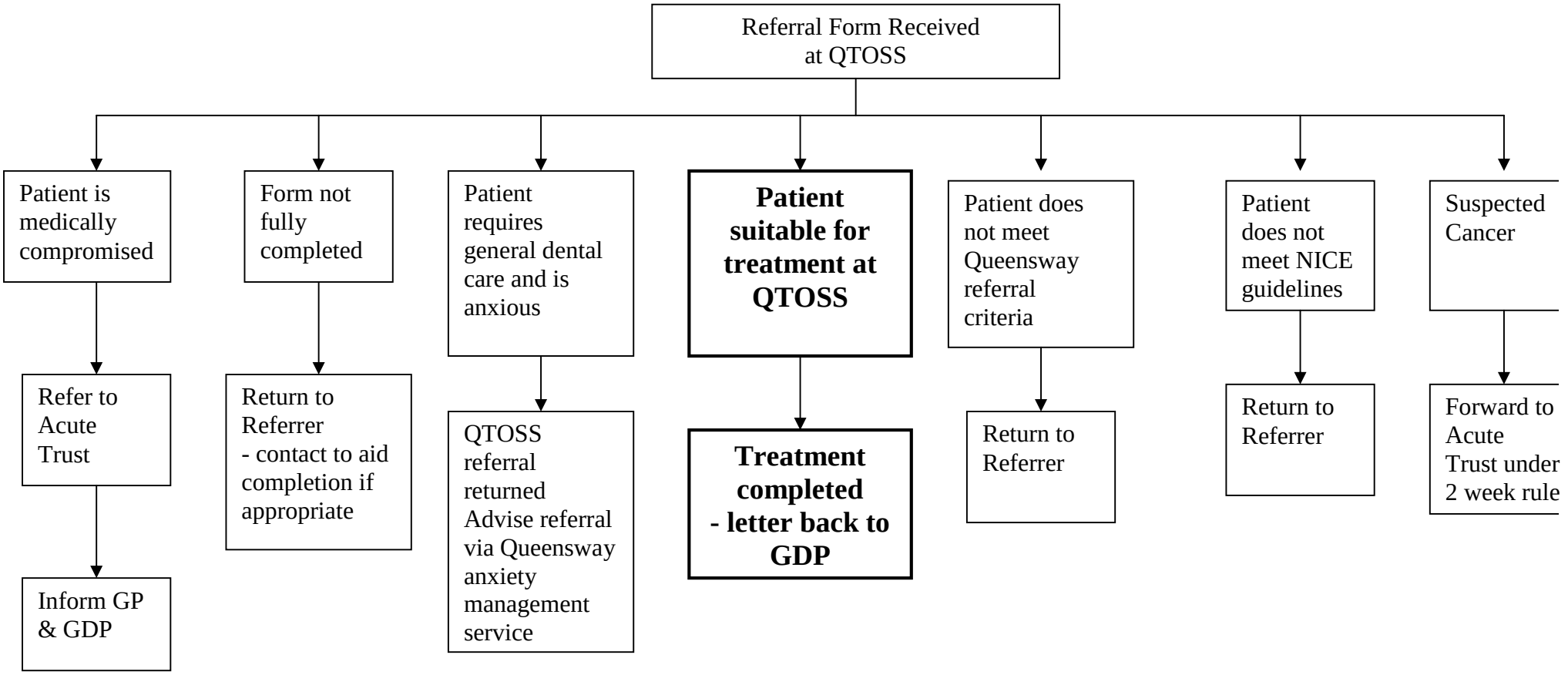
1 DNAs for a first appointment following the initial referral that started an18-week clock nullify the patient's clock (i.e. it is removed from the numerator and denominator for Referral to Treatment time measurement purposes).

Appendix 7: Patient pathway

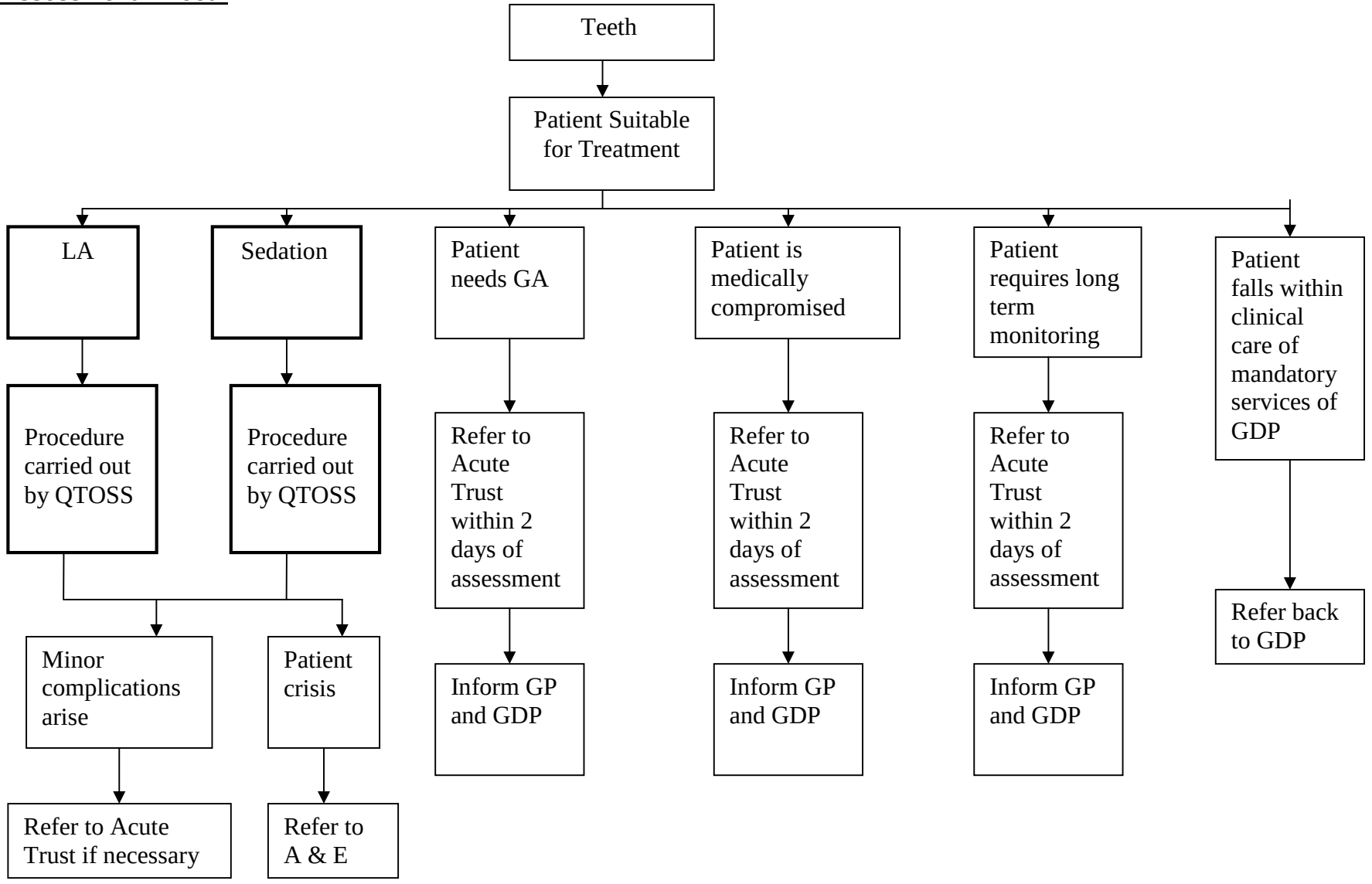
Referral – GDP Referral



Referral pathway when referring to Queensway Teesside Oral Surgery Service (QTOSS)



Clinical Assessment – Teeth



QUEENSWAY

DENTAL PRACTICE

Oral Surgery

QUEENSWAY TEESSIDE ORAL SURGERY SERVICE (QTOSS) REFERRAL FORM

Dr Matthew Dorman BDS (Hons), FDSRCS, FFDRCSI, (Oral Surg), Dip SED

PATIENT DETAILS	
Name:	DOB:
Address:	Work Tel (W): Home Tel (H): Mobile Tel (M): Email (E):

REASON FOR REFERRAL (In accordance with policy referral protocols for patients 16 years and above)	
☐ Extraction of special difficulty ☐ Removal of wisdom teeth as indicated by NICE ☐ Removal of buried roots/fractured or root fragments ☐ Extraction of simple impacted, ectopic or supernumary teeth ☐ Exposure of teeth	☐ Minor soft tissue surgery (polyps, mucocele, hyperplasia) ☐ Apicectomy of single rooted tooth ☐ Minor dental trauma (avulsions/ re-implantation of teeth) ☐ Removal or enucleation of simple dental cysts

INDICATION FOR SEDATION (please tick)			
☐ No indication	☐ Anxiety	☐ Invasive procedure	☐ Co-operation

RELEVANT RADIOGRAPHS ENCLOSED (please tick)		
☐ DPT	☐ Bitewings	☐ Periapical

RELEVANT MEDICAL HISTORY	GMP DETAILS (Must be completed)

REFERRING DENTIST DETAILS	
Name:	
Address:	Telephone: Email:
Signed:	Date:

Address: 170 Queensway, Billingham, Teesside, TS23 2NT
T: 01642 554667 F: 01642 531799 E: dental@queensway.co.uk W: www.queensway.co.uk

For additional copies of this referral form please refer to our website