



**QUEENSWAY DURHAM AND**  
**DARLINGTON ORAL**  
**SURGERY SERVICE**  
**(QDDOSS)**

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## **1. Policy and Protocol Summary (March 2011)**

### **Queensway Durham and Darlington Oral Surgery Service (QDDOSS)**

QDDOSS is designed to complement the hospital oral surgery service managing individuals who do not need to be in hospital for their care, but where the skills of an oral surgery specialist team are required; Access to QDDOSS is targeted, quick, efficient, cost effective and free to patients in a safe primary care environment.

### **Summary of clinical criteria for referral to QDDOSS**

#### **Referrals accepted by QDDOSS:**

- **Patients with GPs in the Durham and Darlington area OVER 17 years of age**
- Patients who fit into an **ASA categories I and II** (patients ASA III may be suitable for LA or Inhaled sedation (IHS/RA) – please contact QDDOSS to discuss individual cases if you are unsure. **(ASA IV are NOT accepted)**)
- 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.**
- Removal of wisdom teeth as indicated by NICE ([www.nice.org.uk](http://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 (in conjunction with an orthodontic treatment plan)
- Exposure of teeth (removal of gum and or bone over the surface of the tooth preventing eruption) in conjunction with an orthodontic treatment plan
- Surgical endodontics on single rooted anterior teeth which have a satisfactory orthograde root filling. **A radiograph must be included with the referral.** (NB re- RCT may be more appropriate and re-apicectomy is not usually indicated)
- Removal or enucleation of simple dental cysts.
- **Benign** minor soft tissue surgery including: Removal of simple fibro-epithelial polyps, mucoceles and denture induced hyperplasia (with no sinister features)

#### **Referrals NOT accepted by QDDOSS**

- Soft tissue lesions of unknown nature/suspected malignancy – including red/white patches. **Such cases need referral to acute trust +/- as 2WW referral**
- Routine exodontias including failed LA
- Significant medical pathology i.e. ASA III and above
- Routine extractions for patients on anticoagulant therapy

**Please note:** we offer treatment as clinically indicated under LA with or without IHS (RA) or IV (intravenous sedation). **We do NOT offer a GA service.** Any patients requiring GA will need appropriate referral to local Oral and Maxillofacial services

## **2. Patient Selection**

### **The service is for:**

- Durham and Darlington patients with permanent teeth referred by their primary care dental or medical practitioners registered with a GP in the area.
- 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 meets 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 (QDDOSS) 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. Referral patterns will be audited and this may lead to individual discussion with referring practitioners if guidelines are not being followed.

### **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 the patient's:**

- Relevant medical history e.g. prescription drugs, heart disease
- Relevant social history e.g. lives on own, does not have own transport, requires a translator (please state the language)
- 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.

### 3. Sedation Assessment guidelines

**The American Society of Anaesthesiologists (ASA)** - Classification of physical status, see below

<b>ASA I</b>	<b>Normal healthy patients</b> - No organic, physiological, biochemical or psychiatric disturbance.	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">Suitable for LA with or without IV sedation or Inhaled sedation</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">Suitable for LA with or without Inhaled sedation</div> <div style="border: 1px solid black; padding: 5px;">Should be managed in secondary care</div>
<b>ASA II</b>	<b>Patients with mild to moderate systemic disease</b> May be due to the condition or pathophysiological processes - eg Well controlled asthma, NIDDM- dietary controlled, mild hypertension - Also: no systemic disease but: extremely nervous (high levels of endogenous adrenaline and > risk of sedation complications), <b>&gt;65years</b> (more sensitive to sedatives and physiology less responsive), obese (< respiratory capacity)	
<b>ASA III</b>	<b>Patients with severe systemic disease which is limiting but not incapacitating</b> - eg stable angina, well controlled epilepsy, chronic bronchitis, congestive heart failure, IDDM, healed MI.	
<b>ASA IV</b>	<b>Patients with severe systemic disorders that are a constant threat to life</b> - eg recent MI, uncontrolled diabetes, uncontrolled epilepsy, severe emphysema – requiring O <sub>2</sub> therapy, cardiac insufficiency etc.	
<b>ASA V</b>	<b>Moribund patients not expected to live more than 24hrs.</b> - Only emergency treatment would ever be provided, e.g. severe trauma.	

#### **ASA guidelines in relation to BP** – Malamed, 1995

BP mmHg	ASA classification
<140 systolic & <90 diastolic	I
140 to 160 systolic & 90 – 94 diastolic	II
160 to 179 systolic & 95-104 diastolic	III a
180 – 199 systolic & 105 – 115 diastolic	III b
>200 systolic & >115 diastolic	IV

#### **Classification of Body Mass Index (BMI)** - as adopted by WHO 2000

Classification	BMI	Risk of non-communicable diseases
Underweight	<18.5	Low (but risk of other clinical problems may be greater)
Normal weight	18.5-24.9	Average
Pre-obese (overweight)	25.0-29.9	Increased
Obese Class I	30.0-34.9	Moderate
Obese Class II	35.0-39.9	Severe
Obese Class III	>40.0	Very Severe

## Fitness for sedation, based on ASA (FDJ 2010):

ALL patients should be given an ASA grade at the time of assessment

ASA grades & BMI	Treatment modalities	Appropriate setting
<b>I &amp; II</b> <b>BMI up to 35</b>	Local anaesthetic (LA) alone LA + Inhaled sedation (also known as IHS and RA) LA + Intravenous (IV) sedation	Queensway dental practice: in surgery operator-sedationist care
<b>III</b> <b>BMI &gt;35</b>	Local anaesthetic (LA) alone LA + Inhaled sedation (also known as IHS and RA)	May be suitable for Queensway dental practice – in surgery operator-sedationist care. <b>Check on individual basis</b>
<b>III</b> <b>BMI &gt;35</b>	LA + IV sedation	Anaesthetic led Sedation, in most cases will require Secondary Care

**NB Max weight limit for dental chairs is 140-150kg**

## Blood Pressure (BP) pre-assessment and day of treatment

- Risks relate to high diastolic values then subsequent use of adrenaline containing LA and possible further elevation.
- Cut-off for listing patients for operator-sedationist IV sedation 180/100 (i.e. within the ASA III a band taking into to effect some degree of 'white coat effect').
- BP values >180/100 should be sent to their GP for monitoring or treatment as appropriate and follow-up appointment made 6-8 weeks later prior to listing. Patient asked to bring series of BP values from practice for our records. NB due to QDDOSS time parameters patients may need to be re-referred.

## Day of treatment

- Pre-operative BP <180/100 – OK to proceed
- Pre-operative BP <180/<105 and normal pre-operative values/ readings from GP (white coat hypertension in non-medicated or medicated anxious patients) – consider proceeding with caution
- Pre-operative BP >180/105 – delay treatment and refer to GP for appropriate management

## Body Mass Index (BMI) & IV sedation (BMI is not an issue with IHS)

- Patients with **BMI >35** are at severely increased risk of co-morbidities including undiagnosed sleep apnoea, cardiovascular and peripheral vascular disease.
- Cut-off at BMI **35** with caveat for clinical judgement for e.g. rugby players
- **NB weight maximum for dental chairs is 140-150kg**
- For Individuals BMI **35 – 40** (and no other medical complaints) *possible* consideration for separate operator & sedationist i.e. Anaesthetic led clinic (with prior discussion with anaesthetist)
- If in doubt any cases BMI **>35** refer to secondary care.
- Patients with a BMI **41>** **not suitable for primary care. Refer to appropriate secondary care facility OR offer treatment with LA or Inhaled sedation.**

#### **4. How to refer**

Please use the referral form for referral of minor oral surgery cases to Queensway can be found in on page 21 (also available as a separate PDF on the website with the summary of clinical criteria for QDDOSS)

All referrals to Queensway **must** use the 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 (NOT treatment on the 1<sup>st</sup> visit).**

#### **CONTACT DETAILS**

The address to refer to Queensway Durham and Darlington Oral Surgery Service (QDDOSS) is:

**Queensway Oral Surgery  
Services**

**293 Yarm Road**

**Darlington**

**Co Durham**

**DL1 1BA**

**Tel: 01325 381928**

**Fax: 01325 381865**

**E-mail: [rebecca@queensway.co.uk](mailto:rebecca@queensway.co.uk)**

***If you require further information please contact Rebecca Hierons on 01325 381928 ([rebecca@queensway.co.uk](mailto:rebecca@queensway.co.uk)). You can also obtain information on the Queensway website: [www.queensway.co.uk](http://www.queensway.co.uk)***

## **5. Other oral surgery 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. haemophilia, 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 or ask them attend the department or Accident & Emergency without having spoken to the department.

### **QTOSS (Queensway Teesside Oral Surgery Service)**

This additional service is available and operates in the same way as QDDOSS for patients from the Teesside areas it is available to under 16s with adult teeth.

Further information can be found in the QTOSS referral policy on our website

## **6. 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 a referral should be made.

### **Indications for referral include:**

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

It is rare that a patient's medical history complicates 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.

## 7. Appendix 2: 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](http://www.rcseng.ac.uk/dental/fds/clinical_guidelines).

**Although there are exceptions referrals should generally 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<sup>1,2,3</sup>.**

**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 therefore will not routinely be undertaken<sup>2,8</sup>.**

Queensway requests that for a referral for a patient 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<sup>4</sup>:**

- 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<sup>4</sup>**

There are few absolute contraindications to endodontic surgery, these contraindications include:

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 Where there is poor supporting tissue
3. The skill, training and experience of the operator may also have an influence on decision making

## **Surgical Outcomes**

### **1<sup>st</sup> apicectomy**

Success rates for apicectomies range from 30% (poorly root treated and inadequately restored) – 80% (well root treated and restored teeth)<sup>5,6</sup>

One newer study using microscopy and MTA suggests a success rate up to 92%<sup>7</sup>

### **Comparison between 1<sup>st</sup> and 2<sup>nd</sup> apicectomies<sup>2,8</sup>:**

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 for 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

## **8. Appendix 3: Routine extraction in warfarinised patients**

Please **do not** refer to the service for routine non-surgical extraction just 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 antiplatelet 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/](http://www.npsa.nhs.uk/nrls/alerts-and-directives/alerts/antiocoagulant/) and are summarised overleaf.



## 9. 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 may also be 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 diagnosed clinically as the presence of exposed bone in the 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 an increasing number of cases being seen and while there have been lots of publications their quality is limited.

##### **How likely is it to affect me?**

Risk of ONJ for oral bisphosphonates 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 that the use of antibiotics should be based on the risk of an infection rather than because the patient is taking a bisphosphonate. Use of 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 discussing 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	<b>NO.</b> ONJ risk is low, standard dental care If not previously a regular attender – patient should attend for a dental examination with management as needed	<b>YES.</b> 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. Atraumatic 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

## 10. **Appendix 5: Antibiotic prophylaxis**

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](http://www.nice.org.uk/CG064)

## 11. Appendix 6: The 18-week 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 patient<sup>1</sup>.
- 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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<sup>1</sup> DNAs for a first appointment following the initial referral that started an 18-week clock nullify the patient's clock (i.e. it is removed from the numerator and denominator for Referral to Treatment time measurement purposes).

## **12. Appendix 7: OAF instructions**

### **What is an OAF:**

OAF stands for an oro-antral fistula (opening) occurring in the upper back teeth region (maxillary). It is a small hole from the upper gum area into the cheek sinus which does not heal after a tooth has been extracted.

### **What are the complications of an OAF:**

- Air can pass through the opening into the opening into the soft tissues of the cheek causing a swelling (Seen if patients stifle a sneeze or try to blow their nose).
- With large defects food can sometimes lodge in the sinus and drinks can come down the nose.
- If untreated in some cases the sinus itself can become infected, antibiotics may be prescribed as appropriate.

### **Treatment of OAF:**

Can be closed by a minor oral surgery procedure either under local anaesthetic alone or in combination with sedation. The site is sutured (stitched closed) and the following advice is given:

### **Post-operative advice:**

- Avoid rinsing on the day of surgery to allow the wound to settle. The following day rinse regularly with warm salty rinses up to 4 times a day (Teaspoon salt in tumbler of cooling previously boiled water – take care not to burn yourself) for 5-7 days.
- Brush and clean the area carefully starting on evening of your treatment including around the sutures.
- 7 days post-op brush the sutures intentionally to make them fall-out more quickly (they will dissolve but may take a number of weeks)
- It is important not to get air into the sinus (this can cause infection). It is very important not to blow your nose after surgery for 2 weeks (or longer if advised).
- A sneeze must not be stifled but allowed to happen naturally.
- You may be given a prescription for antibiotics (with or without a decongestant). You may also use menthol inhalations if you feel congested. You may be offered a review appointment depending upon the size of the OAF.

### QUEENSWAY DURHAM AND DARLINGTON ORAL SURGERY SERVICE (QDDOSS) REFERRAL FORM

Dr Rebecca Hierons BDS FDS RCS  
 Dr Julian Hawkings BSc, BDS, DGD, FDSRCP  
 Dr Wendy Keen BDS FDS RCS

**\*\*\*PLEASE COMPLETE ALL SECTIONS OF THIS FORM OR IT MAY BE RETURNED\*\*\***

Patient details:	
Name:	DOB:
Address:	Home tel: Mobile Tel: e-mail:
POSTCODE (essential):	

Reason for referral (please tick)	
<ul style="list-style-type: none"> <li><input type="checkbox"/> Extraction of special difficulty</li> <li><input type="checkbox"/> Removal of wisdom teeth as indicated by NICE</li> <li><input type="checkbox"/> Removal of buried/fractured roots</li> <li><input type="checkbox"/> Extraction of impacted /ectopic/ supernumary teeth</li> <li><input type="checkbox"/> Exposure of teeth (with Orthodontic treatment plan)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Benign</b> soft tissue surgery (mucocele, polyp, denture hyperplasia) <b>NOT any unknown lesions (need hospital ref.)</b></li> <li><input type="checkbox"/> Apicectomy single rooted, RCT'd teeth <b>(radiograph MUST be included)</b></li> <li><input type="checkbox"/> Removal or enucleation of simple cysts</li> </ul>

Clinic details (teeth indicted for treatment if appropriate)	
R	L
History:	

Indication for sedation (please circle)			
No indication	Anxiety	Invasive procedure	Co-operation

Relevant radiographs (please enclose), ESSENTIAL for apicectomies & multiple extractions)		
DPT	Periapical	Bitewings

Relevant medical history (Essential) ASA I&II	GMP details (essential)

Referring dentist's details (MUST BE FULLY COMPLETED)	
Name:	Telephone:
Address:	email:
Postcode:	Date:
Signature:	

Address: 293 Yarm Road Darlington Co Durham DL1 1BA  
 T: 01325 381928 F: 01325 381865 E:rebecca@queensway.co.uk W: queensway.co.uk

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

## **14. INSTRUCTIONS FOLLOWING DENTAL PROCEDURES AT QUEENSWAY**

### **Cleaning your mouth**

It is important to keep your mouth clean. On the first night do not rinse your mouth out but you should carefully brush the area. In the morning you may use a mouthwash or salt water. After one week you should carefully brush the sutures to accelerate their breakdown.

### **Food & activity**

Stick with soft food until you can chew comfortably. Remember you have had a minor operation so take things easy. We advise time off work where necessary. (Sedation 24hrs)

### **Mouth opening**

Mouth opening is usually restricted to about a fingers width between your front teeth for about a week after wisdom teeth extractions, it then slowly returns to normal.

### **Stitches**

Your stitches are made of absorbable material and will disappear on their own. This can take many weeks(after 7 days gently brush with your toothbrush to break them down quicker) so if you are unsure or concerned telephone us for advice.

### **Pain**

Dental operations can be painful. Afterwards we recommended that you use normal pain killers from the chemist for example Ibuprofen 400mg 3x per day (if you are able to take) with doses of paracetamol 1g 2- 3 hours later no more than 8 tablets (4g) per day i.e. alternate between the two pain killers (don't take at same time). If you are not improving please contact us for a review appointment.

### **Bruising**

This may appear on your face and neck. Do not worry it is quite normal and soon goes away.

### **Swelling**

Your face may swell up for two days after certain operations. It will then take about five days to return to normal. If you are not improving please contact us for advice.

### **Bleeding**

You may bleed from your mouth even though you have been stitched. Do not be alarmed. If the ooze becomes uncomfortable place a cotton handkerchief DIRECTLY over the operation site and bite firmly down for at least 20 minutes whilst remaining quietly seated. Do not rinse your mouth.

### **Numbness**

After some operations your tongue or lip may be numb. This is only temporary but in some cases may last for an indefinite period. If you are numb, please avoid hot drinks and be careful eating, if numbness persists please contact us.

**Smoking:** Please avoid smoking for **at least** 24 hours post – op but the longer the better!!

**If you have any concerns or problems please don't hesitate to contact us – we will be pleased to help.**

Telephone: 01325 381928  
[rebecca@queensway.co.uk](mailto:rebecca@queensway.co.uk)

Website: [www.queensway.co.uk](http://www.queensway.co.uk)

Email:

**Outside normal practice hours, telephone the practice and you will be given the dental on-call for further advice.**

**If you have severe swelling please attend A&E at Darlington Memorial Hospital and ask for the on-call doctor for Oral and Maxillofacial Surgery.**