



Royal College  
of Surgeons  
FACULTY OF DENTAL SURGERY

# Recommendations for Oral Surgery during the recovery phase of the COVID-19 pandemic

June 2020

[www.rcseng.ac.uk/dental-faculties/fds/coronavirus/](http://www.rcseng.ac.uk/dental-faculties/fds/coronavirus/)

## 1. Scope of document

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This document provides advice and guidance to support the delivery of oral surgery care during the COVID-19 recovery and is intended for use by dental teams working in England.

## 2. General principles

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The decision to postpone routine dental care during the COVID-19 pandemic, will inevitably have created a considerable backlog of incompletely treated dental disease in the population as a whole.

Beginning a road to recovery will require a new way of thinking. This will not be a 'return to normal'. As part of this recovery, clinicians will need to completely re-evaluate how services are prioritised and delivered. Relieving pain and managing acute infections must take priority over routine dental care services, especially where environmental issues and other considerations inevitably result in fewer patients being able to be treated in the same time frame. This will not be comfortable, but it is necessary.

As we move forwards during the recovery phase of the COVID-19 pandemic, our philosophy will be to:

- Continue to adhere to the accepted local and national (eg PHE) protocols for the triage of patients with regard to their risk or likelihood of having COVID-19 infection.
- Continue to adhere to the accepted local and national (eg PHE) protocols for the triage of patients with regard to the appropriate Personal Protection Equipment
- Continue to adhere to the local and national (eg PHE) policies regarding protocols for patients and attending staff when there is likely to be an Aerosol Generating Procedure (AGP).
- Provide urgent dental care following an effective system of triage and prioritisation.
- Reduce footfall into clinics in order to maintain social distancing, thus protecting staff and patients.
- Increase our use of health technology to deliver remote consultations and to support self-care.
- Renew our focus on prevention for every patient, at every opportunity.
- Support the commissioning of evidence-based oral healthcare interventions in primary care, community and secondary care.
- Provide evidence-based oral health care and wherever possible carry out procedures that result in the lowest possible exposure to aerosols.
- Ensure services are accessible to all, including those who may be shielded, socially vulnerable or have safeguarding concerns.

#### Recommendation

- Clinical urgency must take priority over referral to treat (RTT) times. Whilst the latter remains relevant, clinical teams must be able to prioritise care on the basis of clinical urgency.

### 3. Delivery of prevention

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Every person should continue to receive tailored oral health advice in line with *Delivering Better Oral Health*.<sup>1</sup> Smoking cessation is particularly pertinent for Oral Surgery and every opportunity to provide smoking cessation advice should be taken.

### 4. Management of conditions managed by Oral Surgery

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The following manifestations may require emergency oral surgery intervention:

- Management of odontogenic infections;
- Management of dental trauma including re-implantation of avulsed tooth/teeth;
- Management of haemorrhage following tooth/teeth extraction;
- Management of post-operative surgical complications.

The following manifestations may require urgent oral surgery intervention:

- Management of oral and dental infections;
- Dental assessment and associated treatments prior to oncological or other medical management;
- Solitary ulceration or swelling of the oral mucosa or swelling of the jawbones that has persisted for at least two weeks and is unlikely to reflect local trauma and/or dental infection;
- Area of paraesthesia/anaesthesia of the trigeminal region that has no obvious local cause (eg trauma or infection);
- Suspicious oral lesions;
- Dental assessment and associated treatment for patients receiving oncological care;
- Acute lymphadenopathy, or progression of pre-existent lymphadenopathy of the head and neck.

No patient should attend without first being triaged by telephone/video. This should be carried out by an experienced clinician and could be run remotely from the dental setting if needed.

Clinicians are likely to continue working remotely for initial screening of their patients and as such can be encouraged to submit queries via advice and guidance via ERS and in the same way photographs can be attached which aids giving advice. Many of these cases need not be referred after simple guidance.

Patients should continue to be triaged according to the Royal College Surgical Priorities published at the start of the pandemic, in order to prioritise which patients are brought into clinic first.

Category 1a – Emergency, operation needed within 24 hours, 1b – Urgent, operation needed in 72 hours

Category 2 – Surgery that can be delayed 4 weeks

Category 3 – Surgery can be delayed for up to 3 months

Category 4 – Surgery that can be delayed for more than 3 months

The cessation of primary care dentistry and together with the advice to manage infections with antibiotics and avoid AGPs is likely to result in an increase need for dental treatments including extractions as dental services gradually return to normal. There is likely to be an increased referral to specialist and secondary care centres for the surgical removal of teeth and this increased demand must be managed in an environment where fewer patients are able to visit clinics in the usual manner.

The 2WW pathway is unchanged for patients with suspected malignancies.

Ensure that patients on oncological pathways awaiting a dental assessment are prioritised and that subsequent oncological care is not delayed.

Clinicians vetting referrals already have the requisite skills to prioritise the cases as they are referred but advantage should be taken of the increase in digital tools such as video consultations to improve triage.

## 5. Treatment Modality

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### a) Local anaesthesia

Treatment with local anaesthesia is safe to proceed and therefore biopsies of oral mucosal lesions can be undertaken as a biopsy is not an AGP. Likewise intralesional injections and cryotherapy can be scheduled according to urgency of procedure as neither these involve an AGP.

### b) Inhalation sedation

Inhalational sedation can support patients to manage treatment and potentially avoid a general anaesthetic (GA). However, there remains a lack of consensus concerning the safety of providing inhalation sedation during the COVID-19 recovery and clarification is awaited from NERVTAG.

Recommendations

- Await clarity from NERVTAG regarding safety of inhalation sedation during COVID-19 recovery phase, along with whether inhalation sedation should count as an AGP, thus requiring enhanced PPE in line with PHE guidance.<sup>2</sup>

- Await clarity on decontamination protocols from NERVTAG, specifically whether there is a need to move to disposable nasal hood and tubing or a confirmation that current sterilisation processes are sufficient.

### **c) Intravenous sedation**

Treatment with intravenous sedation is safe to proceed, subject to safe staffing levels and national guidelines.<sup>3,4</sup>

### **d) General anaesthesia**

Many oral surgery procedures cannot be treated unless care is provided under general anaesthetic (GA). During the COVID-19 pandemic, all elective activity was cancelled so that theatre space, equipment and manpower could be redeployed as part of the NHS wide COVID-19 response. It will be challenging to re-establish access to theatre time and this is likely to take place in a phased approach to allow for the return of redeployed staff and currently repurposed theatre/recovery space. Failure to provide increased access to GA will result in an increased pressure on the wider system with increased calls to 111, attendances at A&E and calls to General Medical Practitioners.

Elective patients should be admitted and pre-operatively tested in line with national guidance. Airway management should not change in response to the COVID-19 crisis.<sup>5</sup> Clinical urgency must take priority over Referral to Treatment (RTT) when selecting patients for admission. Sessional use of FFP3 can be employed, in line with PHE guidance<sup>2</sup> for the operating surgeon and assisting nurse.

General Dental Practitioners should provide ongoing support and Advice, Analgesia and, if indicated, prescription of Antimicrobials (AAA) whilst a patient is waiting for treatment under GA. Where possible, removal of the source of pain and/or infection should be attempted.

For the foreseeable future the following patients should be prioritised for urgent treatment under GA:

- Patients who have sustained trauma to the permanent dentition/dentoalveolar/orofacial skeleton and soft tissues where treatment under local anaesthetic or local anaesthetic with intravenous sedation is not possible.
- Patients whose poor dental health is impacting on, or is highly likely to impact on, their medical health, eg patients with diabetes, cardiac conditions, epilepsy or inherited metabolic disorder – and a decision is made that the benefits of surgery outweigh the risks of bringing a patient into hospital during the COVID-19 pandemic.
- Patients who have acute dental infections that are not responsive to antibiotics which cannot be managed under local anaesthesia or local anaesthetic with intravenous sedation.
- Patients with additional needs such as those with learning disabilities or autism, where dental pain is resulting in self harm or other disruptive or detrimental behaviours.
- Patients who require EUA +/- biopsy in order to establish a diagnosis in possible malignant or other urgent conditions.
- Patients with lesions/conditions where absence of prompt treatment will lead to harm, serious exacerbation of the condition or deterioration of the patient (eg pre radiotherapy extractions).

## 6. Care of medically complex patients

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For patients with medical 'red flags', discussions with their medical team may help decision making and should be encouraged.

Priority should be given to:

- Patients with underlying medical conditions which place them at greater risk of complications arising from any subsequent infection if the surgical problem is not resolved.
- Patients with additional needs such as those with learning disabilities or autism, where the oral mucosal problem is having a severe impact on the child/family with evidence of adverse behaviours such as self-harming.

The list below, although not exhaustive, provides examples of potential 'red flag' conditions that may exacerbate/complicate an adult's presenting condition and should be taken into consideration when justifying the need for urgent care:

- Increased risk of bleeding from medications or conditions (eg chronic renal failure, liver disease, haematological malignancy, recent or current chemotherapy, idiopathic, inherited bleeding disorders including all types of haemophilia and von Willebrand's disease).
- Increased risk of infection (eg any immunocompromised state, transplant patient, diabetic, adult on immunosuppressants/steroids/chemotherapy).
- At increased risk of infective endocarditis.
- Additional needs eg a communication or behavioural needs (eg severe autism) that potentially place them and their families at greater impact from orofacial and mucosal symptoms.

## 7. Shielded patients

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There are people who are identified as being at significantly increased risk from COVID-19.<sup>6</sup> The decision to bring these patients into a hospital or dental clinic environment during the recovery phase should be decided after careful consideration of the risks and benefits: Clinically extremely vulnerable people may include the following people. Disease severity, history or treatment levels will also affect who is in this group.

- Solid organ transplant recipients.
- People with specific cancers:
  - » People with cancer who are undergoing active chemotherapy;
  - » People with lung cancer who are undergoing radical radiotherapy;
  - » People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment;
  - » People having immunotherapy or other continuing antibody treatments for cancer;
  - » People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or parp inhibitors;

- » People who have had bone marrow or stem cell transplants in the last six months, or who are still taking immunosuppression drugs.
- People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary (COPD).
- People with rare diseases that significantly increase the risk of infections (such as severe combined immunodeficiency [SCID], homozygous sickle cell).
- People on immunosuppression therapies sufficient to significantly increase risk of infection.
- Women who are pregnant with significant heart disease, congenital or acquired.

These patients require care in a separate geographical location to non-shielded patients. We must ensure that medically complex patients have their oral health needs met as an integrated part of their general health thus minimising the need for additional contacts in the dental environment where the oral surgery team operates.

## 8. Safeguarding

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Remember that our responsibilities to safeguard patients continue during the pandemic and its aftermath. Be aware that our patients may be exposed to increased risks of abuse, particularly domestic abuse.<sup>7</sup> If you have concerns that a patient is being abused or do not hesitate to seek further advice from usual sources. Likewise if a patient's mental health has deteriorated as a result of the pandemic restrictions to their daily life then consideration should be given to prioritise an assessment for these patients.

## 9. Preparation of the patient prior to face-to-face contact

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These questions are the same for all dental specialties

- Ask a patient about a history of cough, and/or fever, self-isolation and loss of taste/smell. Non-urgent treatment for patients who are displaying COVID-19 symptoms should be delayed.
- It is recommended that patients do not have a person accompanying them unless an escort is essential for support.
- Consideration should be given to history taking via digital means prior to attendance to minimise face-to-face time required in the clinic.

The NHS has several digital options available for remote Consultations. Attend anywhere (<https://england.nhs.attendanywhere.com/resourcecentre/Content/Home.htm>) is just one example and hosts trusts for oral surgery services are likely to have piloted use of one of these systems already.

## 10. Resources to support self-care

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Patients should be encouraged to perform optimal self-care in order to minimise the development of new disease. Use of digital health tech can be used to deliver and reinforce key prevention messages. Various resources are available on society webpages for patients requiring oral surgery.

## 11. Workforce issues

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Undoubtedly, in the recovery phase, there will be significant workforce issues that may challenge our capacity to provide dental care for children and young people. These may include:

- temporary/permanent reductions in the overall availability of dental team members due to shielding, self-isolating, child-care demands, or mental health considerations;
- the need to change working patterns, such as extending the working day, to compensate for less 'efficient' clinic usage than previously possible;
- the impact on undergraduate and postgraduate clinical training which will have serious longer-term implications for the workforce.

An integrated and flexible workforce made up of primary and secondary care overseen by the MCN will help to ensure that pathways are streamlined and care is delivered as effectively as possible.

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