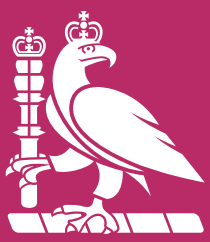

Royal College of Surgeons

FACULTY OF DENTAL SURGERY

Recommendations for Restorative Dentistry during the recovery phase of the COVID-19 pandemic

June 2020

www.rcseng.ac.uk/dental-faculties/fds/coronavirus/

1. Scope of Document

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

2. General principles

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 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.[2]
- 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 Procedures (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.
- Provide a gradual return to treatment to patients with restorative needs with priority given to those patients with acute symptoms, tooth fracture and failing restorations.
- 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, lower Aerosol Generating Procedures (AGPs) oral health care in preference to higher AGPs, wherever possible
- Ensure services are accessible to all, including those who may be shielded, socially vulnerable or have safeguarding concerns.

- 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

Every person should continue to receive tailored oral health advice in line with Delivering Better Oral Health.[1] Oral health advice can be given as part of a remote consultation using the resources listed in section 13. With oral health services under pressure to manage existing disease, it is critical that we maximise efforts to prevent new disease. Every opportunity to provide smoking cessation advice should be taken.

4. Management of conditions managed by Restorative Dentistry

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.

GPs 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. Colleagues are encouraged to refer to guidance from Specialist Societies regarding specific management protocols.

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, treatment needed within 24 hours. 1b – Urgent, treatment needed in 72 hours

Category 2 – Treatment that can be delayed 4 weeks

Category 3 – Treatment that can be delayed for up to 3 months

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

Emergency and Urgent (category 1a and 1b):

- Dental Trauma (including facial) that requires immediate care and splinting;
- Orofacial swelling that has not responded to antibiotics;
- Severe dental pain (symptomatic irreversible pulpitis, symptomatic apical periodontitis) not responding to OTC analgesics;
- Acute apical abscess not responding to antibiotics;

- Fractured or failing restorations (including implant-supported) where there is a risk of inhalation;
- Fractured or failing restorations (including implant-supported) associated with traumatic ulceration;
- Acute periodontal abscess.

Elective up to 4 weeks (category 2):

- Follow-up of dental trauma cases that require splint removal;
- Patients that have had previous bone grafting and who require further care, for example, dental implant placement;
- Patients undergoing treatment for fixed conventional or dental implant retained rehabilitation and with provisional restorations in-situ which have lost cementation or fractured;
- Patients where master impressions have been made for the construction of resin-retained bridgework.

Elective up to 3 months (category 3):

- Completion of straightforward and moderately difficult conventional endodontic (primary and secondary) treatment on teeth that are dressed, ideally in one visit if clinical and operator parameters allow, including direct core-restorations;
- Dental trauma review, and completion of endodontic treatment of cases as required;
- Non-surgical periodontal treatment where no treatment is likely to cause tooth loss, depending on current periodontal classification (Grade C). If tooth were to occur, this would significantly affect form, function and wellbeing;
- Patients for whom bone grafting/socket preservation has been provided and who require further care, for example, dental implant placement;
- Periodontal surgery. Management of gingival recession around teeth or dental implants which if not provided will result in worsening of the current situation or tooth/dental implant loss. Gingival recession which significantly affects appearance;
- Periodontal regeneration where the diagnoses is stage III/IV and grade B or C with no risk factors;
- Dental implant (stage 1 surgery) where loss of space could occur, for example, recent post-orthodontic treatment;
- Tooth loss and planned dental implant surgery which if not undertaken within 6-8 weeks of tooth loss will result in increased treatment need and compromised outcomes;
- Patients undergoing treatment for fixed conventional or dental implant retained rehabilitation and with provisional restorations in-situ;

- Patients undergoing treatment to provide conventional or dental implant retained removable prostheses.

Routine after 3 months (category 4):

- Completion of conventional endodontic (primary and secondary) treatment on teeth of all complexities, ideally in one visit if clinical and operator parameters allow, including direct core-restoration;
- Dental trauma review;
- All other non-surgical periodontal care not mentioned in the categories above;
- Endodontic (apical) microsurgery;
- All other periodontal surgery not mentioned in the categories above;
- Patients undergoing treatment for intra-coronal restorations;
- Treatment of localised or generalised tooth wear with adhesive restorations;
- Patients who have been accepted for dental treatment and awaiting first appointments for:

    (a) Dental rehabilitation using fixed-movable prostheses

    (b) Dental implant treatment

    (c) Complete dentures/over dentures

    (d) Removable partial dentures/over dentures

    (e) Resin-retained bridges

    (f) Composite resin restorations

    (g) Limited crowns, onlay restorations or bridges

Any patient on immunosuppressants would be prioritised as category 2, and have been managed remotely in the urgent dental care phase. There will be a need to continue to manage the medication dosages for these patients. This activity is likely to be needed for some time as many of these patients will be classified as extremely clinically vulnerable (see sections 6 and 7).

Restorative procedures that require an aerosol generating procedure (AGP) should be performed with all efforts to mitigate the risk of transmission of the SARS-Cov-2 virus (ie rubber dam isolation, high-volume aspiration) and for minimal working times with the appropriate PPE and infection control protocols.

5. Treatment Modality

a) Local Anaesthesia

Treatment with local anaesthesia is safe and essential for procedures involving the pulp, treatment of dental caries, and removal of failing restorations.

b) Intravenous sedation

Treatment under intravenous sedation is safe to proceed, subject to safe staffing levels and national guidelines.

6. Care of medically complex patients

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 that place them at greater risk of complications arising from any subsequent infection.

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 dental pain and/or infection.

7. Shielded patients

There are people who are identified as being at significantly increased risk from COVID-19.[3] 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 6 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 Restorative Dentistry team operates.

8. Safeguarding

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.[4] If you have concerns that a patient is being abused or do not hesitate to seek further advice from usual sources. Likewise is 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

- 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.

10. Resources to support self-care

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:

- The British Society for Restorative Dentistry www.bsrd.org.uk
- The British Society of Prosthodontics www.bsspd.org
- Restorative Dentistry – UK www.restdent.org.uk
- The British Endodontic Society https://britishendodonticsociety.org.uk
- The British Society of Periodontology www.bsperio.org.uk

11. Workforce issues

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.

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Acknowledgements

The development and production of this guidance was led by Dr Sanjeev Bhanderi on behalf of the British Society of Endodontics and Mr Matthew Garrett on behalf of the Faculty of Dental Surgery, Royal College of Surgeons of England and in collaboration with the British Society for Periodontology.