

**Periodontal Referral Guidelines**

The guidelines provided are designed to ensure that referrals are appropriate and of sufficient quality, allowing us to appoint patients with true need in an efficient manner. It is accepted that, on occasions, it may be unclear if a referral is appropriate or not. If in doubt, it would be preferable to seek advice from the Consultant team via the Consultant’s secretary. Patients are accepted where they require:

* Treatment by a specialist
* Fulfil the current training need for an undergraduate or postgraduate clinical student

Occasionally, it may be necessary to refer patients who are new to the practice and who may have previously received care regularly elsewhere. In this situation, the patient will be advised of the diagnosis and treatment required and will be requested to return to the referring dentist for treatment where appropriate.

It is the GDP’s responsibility to inform the patient of the exact purpose of the referral and that there is NO GUARANTEE of treatment being provided at CCDH. The patient should understand that he/she will be advised of the problem(s) but may not necessarily be accepted for treatment at the hospital.

Patients referred on an economic basis will not be accepted.

We accept referrals for:

Periodontitis

Non-surgical management should be undertaken in the primary care setting initially. Only if a BPE code 4 persists **following an initial cycle** **of non-surgical therapy in primary care in combination with improved plaque control to below 40%**, is it appropriate to refer. The referral is appropriate:

* + Where full pre-operative 6 point pocket chart, plaque & bleeding scores have been taken and a cycle of non-surgical management provided (with or without local anaesthesia)
	+ Radiographs of diagnostic quality, clearly showing the bone levels of affected sextants. Digital radiography should be sent on a disc correctly formatted as per guidance (**Appendix 1**) and with patient name and exposure date.
	+ Confirmation and summary of prevention strategy delivered, including self-performed plaque control training, interdental cleansing and smoking cessation where appropriate
	+ Where the patient is motivated to improve their oral health or relevant reasons why a patient may struggle to self-care. If there has been difficulty in this area, please indicate so we can appropriately direct the patient to care within Charles Clifford
	+ Where there are systemic conditions modifying the disease process or response to treatment
	+ Post-operative indices taken at least 8 weeks following therapy
	+ Where the patient is motivated to improve their oral health
	+ Where the level of periodontal destruction is inconsistent with the level of plaque control present, in a typically younger patient (though not exclusively), no active medical factors or risk factors and a positive family history.

Periodontal surgery may be considered as part of holistic treatment planning and where clinically appropriate, in the presence of optimal self-performed plaque control. Certain surgical procedures are not undertaken on smokers.

Gingival conditions

Following preventive advice and removal of plaque retentive factors, referral may be warranted for non-responsive gingival inflammation or localised recession defects, where self-performed plaque control is as optimal as can be for the patient. No Supragingival calculus should be present.

Recession defects which do not exceed Millers I/II may be referred for consideration of periodontal plastic surgery where indicated. Millers III/IV defects are unlikely to be surgically restored to near original gingival architecture. Advice may be sought.

Drug Induced Gingival Overgrowth can occur with the use of some calcium channel blockers, anti-epileptic medication and immunosuppressant therapy. Referral for advice and treatment welcomed following patient education in optimally self-controlling plaque levels.

Crown lengthening surgery can be performed to facilitate restorative dentistry and allow access to subgingival restoration margins or to correct excess/asymmetric gingival display. This can only be considered where:

* no other dental disease is present
* in patients with excellent plaque control
* with no systemic contraindications to surgery
* in non-smokers.

The Consultant will assess the feasibility of the treatment plan, prior to performing the surgery where appropriate. Radiographs clearly showing bone levels of area proposed for surgery are required.

Clinical photography can be very helpful for diagnostic & planning purposes. Please enclose if available.

Necrotising conditions

These should be managed in primary care comprising analgesia, non-surgical management, instruction to patient to perform adequate plaque control, elimination of risk factors such as smoking and stress and systemic antimicrobial therapy should be used. Non-responsive or recurrent cases may be referred and underlying systemic immunosuppression should be considered.

 Perio-Endo lesions

Where there are suspected perio-endo lesions, it is advisable to **provide the primary endodontic therapy in the primary care setting**, unless the tooth falls within the remit of the specialist endodontic referral pathway at CCDH. Simple endodontic therapy may be suitable for our undergraduate dental students. More complex therapy may be suitable for a senior trainee or appropriately trained member of staff via the endodontic referral pathway. Please indicate this if necessary.

Only teeth of strategic clinical importance will be considered for treatment where appropriate.

Peri-implantitis

Only implants placed under the care of CCDH or NHS will be treated for peri-implantitis.

All others placed in primary care must be facilitated in primary care with an appropriately trained clinician. Treatment for acute infection, sepsis and pain may be facilitated by the Hospital, though the longer term care will be provided in primary care. Advice and second opinion may be requested.

Complex dental problems including periodontal issues

Patients with complex problems such as those requiring co-ordinated multi-disciplinary treatment involving endodontics, prosthodontics, orthodontics and/or implants will be considered. Shared care treatment strategies may be employed in these cases between specialist disciplines and primary care.

Medical complications

Patients with significant medical factors that may affect adversely affect periodontal status such as syndromes, medications, medical treatments, immunosuppression and oncology may benefit from specialist opinion and treatment where appropriate.

Referral exclusions

The following categories of patient should not be referred:

• Irregular attenders at dental practices.

• Patients who are Requesting referral based on economic grounds

• Patients who consistently demonstrate poor self-management of plaque control and lack of uptake of preventive health advice.

**Patients accepted for periodontal treatment shall continue to remain under the care of their own GDP for routine dental examinations and any acute treatment required, alongside the course of specialist level therapy undertaken at the hospital. Patients are responsible for attending their regular dental examinations.**

On completion of periodontal treatment, a discharge summary will be provided with final outcome, treatment undertaken and a personalised surveillance & maintenance strategy for the primary care setting.

Referral process

Referrals can be made on the provided forms which ensure all information required is provided. At a minimum, all referrals must contain the following information:

* Patient name, address, contact details
* Relevant medical and social history
* Provisional diagnosis including the results of special tests
* Summary of treatment undertaken to date, including prevention and stabilisation
* Plaque and bleeding scores (%)
* Smoking status with indication of cessation advice given
* Indication of recession with clinical photograph if available.
* BPE Score. In line with BSP Guidelines where BPE code 3, there should be a 6 point pocket chart in those sextants only. Where a code 4 presents, full mouth 6 point pocket indices should be enclosed
* Radiographs of diagnostic quality **clearly showing the bone level of affected areas**, unless there has been a specific and stated reason not to take one.

Failure to include this information will render the referral unsuitable and it will be returned to the referring clinician. We need this information to streamline the consultation process at the hospital and ensure an effective and efficient service for patients. We appreciate your cooperation in the provision of information!

**Appendix 1: Guidelines on how to label radiographs sent to CCDH**

IMAGE FORMAT

CONVENTIONAL

DIGITAL

MULTIPLE EXPOSURE DATES

Yes

INDIVIDUAL CD ROMS FOR EACH EXPOSURE DATE

No

 No

  

 **Patient name**

 **DoB**

**Exposure** **date**

**Patient name**

 **Date of Birth**

**Date of exposure**

**LABEL CD/VIEW MOUNT**

**PATIENT’S NAME, DOB & DATE OF EXPOSURE**