Sheffield Teaching Hospitals NHS
NHS Foundation Trust

CCDS 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

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 CCDS. 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.

Appropriate referrals include referrals for:

Periodontitis	Appropriate cases: • Severe periodontal disease (Stage III/IV) where primary care treatment has been unsuccessful and plaque score <20%. • Rapidly progressing periodontal disease (Grade C), judged by severity of periodontal destruction relative to age or rate of periodontal breakdown in presence of plaque score <20%. Non-surgical management should be undertaken in the primary care setting initially. Only if a BPE code 4 persists **following at least one cycle of non-surgical therapy in primary care, in combination with a plaque score of 20% or below (or a demonstratable reduction by 50%**), is it appropriate to refer. The referral is appropriate: • Where full pre-operative 6-point pocket chart, plaque & bleeding scores have been taken • Where radiographs of diagnostic quality have been taken, 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 cleaning and smoking cessation where appropriate • Where the patient is engaged and motivated to improve their oral health or there are relevant reasons why a patient may struggle with self-care. • Where there are systemic conditions modifying the disease process or response to treatment • Where at least one recent cycle of non-surgical management has been provided including sub gingival professional mechanical plaque removal in pockets equal to and over 4 mm (with local anaesthesia) • Where post-operative indices have been taken at least 8 weeks following therapy • 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. <u>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.</u>

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 RT1 / 2 (Millers I/II) may be referred for consideration of periodontal plastic surgery where indicated. RT3 (Millers III/IV) defects are unlikely to be surgically restored to near original gingival architecture. Advice may be sought.
Drug induced gingival overgrowth	This can occur with the use of some calcium channel blockers, anti-epileptic medication and immunosuppressant therapy. Referrals for advice and treatment are welcomed following initial non-surgical therapy in engaging patients with optimal plaque control.
Crown lengthening surgery	This may 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 through 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.
Endo-Periodontal Lesions	Where there are suspected Endo-Periodontal 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 CCDS. Only teeth of strategic clinical importance will be considered for treatment where appropriate.
Peri-implantitis	Only implants placed under the care of NHS service will be treated for peri-implantitis. All others placed in primary care must be managed 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. The acceptance of such patients may change over time depending upon departmental capacity.
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 conditions	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 engagement in preventive oral 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.

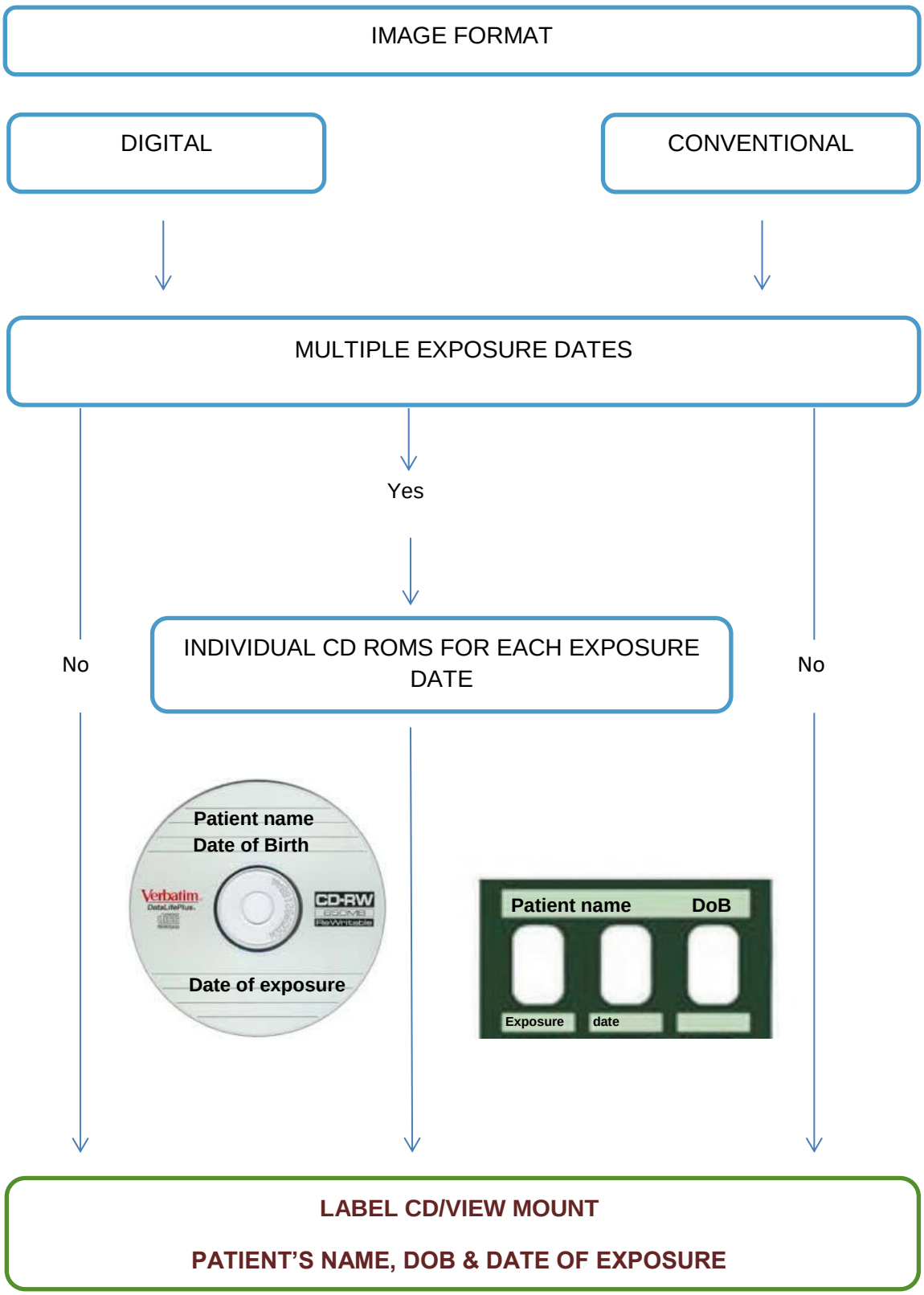
Referral process

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 photographs 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 at the 3-month review following initial periodontal therapy. Where a code 4 presents, full mouth 6-point pocket indices (pre and post treatment) should be enclosed (with dates of the examinations).
- ✓ Radiographs of diagnostic quality **clearly showing the bone level of affected areas (with dates of the examinations)**, 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. A flowchart that can assist with the referral process can be found in **Appendix 2**. We appreciate your cooperation in the provision of information!

Appendix 1: Guidelines on how to label radiographs sent to CCDS



Appendix 2: Periodontal Referral Pathway Flowchart for CCDS