Management of Acute Dental Problems – Telephone Interviews

The Guidance Development Group (GDG) reviewed the following points and whether the guidance text should be amended. For several of the points below, resulting amendments to the guidance are indicated in blue. If there is no amendment, either there was no suggestion for change or having considered the comment, the GDG felt that no change was necessary.

General comments

- Good tool for anyone, clinicians or not.
- Guidance not specifically aimed at dentists, more for other health care providers or designed with out of hours tri-age in mind. It provides the best advice for patients phoning in with a problem and not necessarily showing up at a dental practice.
- The Introduction was very strong and starts a bit aggressive or perhaps it is poor choice of words *("some patients may have to re-attend for a procedure to be repeated or for an alternative treatment because the initial care itself was sub-optimal."*) The argument is that some patients need to re-attend for review or even if the best treatment is given it might not work. The choice of words might put some dentists' noses out of joint.

Acknowledged that the wording of the introduction might have appeared off-putting and has been amended

- The guidance would be useful for other health care professionals, particularly those tri-aging on NHS 24 and GPs, but possibly not as useful for pharmacists as the terminology is likely to be less familiar to them.

A glossary has been added and some of some of the terminology replaced with less specialist terms

- For non dentists, there may be too much dental information that won't be familiar to other health care professionals, particularly for the swelling and bleeding pathways
- The layout of the guidance is good, written in a clear and concise way. Although some of the pathways look daunting at first, when you go through them they all make sense. It would be good to have the guidance in a small laminated version that could be used/referred to during clinical care.

A concise version of the guidance that includes only the flowcharts will be provided and distributed.

Times/Referrals

- When does the clock start for the timings – for example in the case of trauma, is the 60 minutes from when the trauma occurs or when they turn up at the dentists.
- The timings, although realistic in some instances they are impossible due to location. It depends on the geographical area and how accessible points of referral are.

Have clarified in the text that timescales are included as a guide and should be met if possible, but that there are circumstances when this is not possible

- Would be useful to have information on where the local referral hospitals are

- Referral to emergency care – via A&E and not necessarily NHS 24 – don't understand how NHS 24 works. Some dentists would phone the hospital first, others would phone 999 for more serious injuries (severe bleeding, breathing difficulties etc.)

A brief description of how emergency dental care is provided in Scotland, including the role of NHS 24, is now included.

Pathways to providers of care

- The use of antibiotics are presented in the guidance as a last resort but there are circumstances when it is appropriate to prescribe an antibiotic, for example, severe swelling, can't get drainage, assume the swelling will get worse so do prescribe antibiotic.

Have added that although local measures are usually preferred over prescribing an antiibiotic, rarely it might be necessary to prescribe an antibiotic.

- In the bleeding pathway at stage – *several conditions can cause low level bleeding. Assessment by a dentist is required, the recommendation is prompt dental care within 7 days*. One dentist felt that this should be immediate dental care and not within 7 days.

- In the injury caused by trauma pathway (page 9) at step – *most small intra-oral lacerations do not require suturing. Advise optimal analgesia and patient to maintain good oral hygiene.* One dentist felt that the end point here should be to seek dental care within 7 days as the problem could be a tooth fracture or a piece of broken tooth that might have got into the tissue that a patient is not aware of.

- In the dental trauma pathway (page 10) at the stage where an adult tooth has been knocked out. The guidance recommends to *place the tooth in milk. Avoid handling the root. Reimplantation has better success within 6 hours or patient is <16 yrs old.* One dentist felt that there was an omission from this pathway and there should be an option for the situation when the tooth can be orientated, then it should be reimplanted immediately.

Have amended to include that immediate reimplantation is preferable, if feasible.

Section 3

- In section 3.3 on necrotizing gingivitis and necrotizing periodontitis, under the key signs and symptoms section there was nothing for necrotizing gingivitis on its own. This could have been laid out slightly better. In the subsequent care section, one dentist commented that they would consider systemic investigation if a young, fit, healthy non smoker came in with necrotizing gingivitis, they would consider the possibility of glandular fever or something more systemic involved in why they were getting this condition.

The key signs and symptoms have been amended to clarify that both gingivitis and periodontitis are included. (Agreed not to amend in light of the other point made)

- In section 3.4 on post extraction haemorrhage the subsequent care section recommends considering *suturing the wound to achieve good soft-tissue closure and/or to stabilise the socket edges*. One dentist commented that they would not do this if a patient was on warfarin. In their experience suturing in this instance will not stem the blood flow and in fact it might bleed more.

- In section 3.6 on subsequent care for dry socket, one dentist felt that if there is a risk associated with the use of chlorhexidine, then maybe they should just be irrigating with something like saline instead.

The recommendation to irrigate with chlorhexidine has been removed and a note about the very rare risk of anaphylaxis added.

- In section 3.14 on injuries to the mouth face and jaws and in the subsequent care section on dento-alveolar injuries (page 33) it is recommended to consider *applying a flexible splint for up to 1-4 weeks, after replanting a permanent tooth.* One dentists felt that the time frame here (1-4 weeks) was very vague and quite a large difference in time. They didn't know for sure what exact time should be but felt it was something like 10 days. It was felt that the time scale should be tightened up a little.

Factors that influence for how long the splint should be applied are now included.

Emergency Dental Care Guidance

- Half of the dentists were not aware of the Emergency Dental Care Guidance and the other half were aware of it but did not use it regularly. One dentist commented that they read it when it came in but it was then filed away.

- The only suggestion or comment about it was the format and it might be better in a small clearly sectioned document.