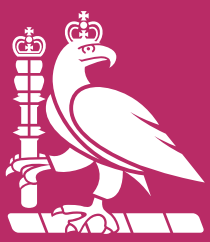

Royal College of Surgeons

FACULTY OF DENTAL SURGERY

Recommendations for Oral Medicine 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 Oral Medicine 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.[1]
- 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.
- Maximise use of health technology to deliver remote consultations and to support self-care.
- Maintain 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 Procedure (AGP) oral health care in preference to higher AGP procedures, wherever possible.
- Provide evidence-based, non-Aerosol Generating Procedures (AGP) in preference to AGP, wherever possible.
- 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

Every person should continue to receive tailored oral health advice in line with Delivering Better Oral Health.[1] Smoking cessation is particularly pertinent for Oral Medicine and every opportunity to provide smoking cessation advice should be taken.

4. Management of conditions seen by Oral Medicine

The following manifestations may require urgent oral medicine intervention:

- Solitary ulceration or swelling of the oral mucosa or swelling of the jawbones that has persisted for at least 2 weeks and is unlikely to reflect local trauma and/or dental infection (but cancer is not suspected).
- Severe oral mucosal and/or gingival ulceration/blistering that has persisted and/or become widespread over 2 weeks.
- Area of paraesthesia/anaesthesia of the trigeminal region that has no obvious local cause (eg trauma or infection).
- Acute onset loss of motor function of the face or mouth.
- Acute swelling, or progression of pre-existent chronic swelling of a major salivary gland.
- Acute lymphadenopathy, or progression of pre-existent lymphadenopathy of the head and neck.
- Severe orofacial pain not responding to over the counter analgesics.

Patients should, predominantly, not attend without first being triaged by telephone/video. This should be carried out by an experienced clinician and should be run remotely from the dental setting if needed.

Clinicians particularly GPs and General Dental Practitioners are likely to continue working remotely for initial screening of their patients and as such GPs can be encouraged to submit queries for advice and guidance via ERS or normal referral pathway. In the same way photographs/video can be attached to any electronic queries to aid an Oral Medicine specialist giving advice. Many of these patients may ultimately not require to be referred after simple advice and guidance remotely.

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

Category 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

Any patient on an immunosuppressant and patients with dysplasia would predominantly be prioritised as category 2, and would have been managed remotely by their Oral Medicine team or GP 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 to be done for some time as many of these patients will be classified as extremely clinically vulnerable (see sections 6 and 7).

The gradual re-opening of primary care dentistry is likely to continue to generate increased referral to specialist and secondary care centres for the management of oro-facial disease within the remit of Oral Medicine. This demand must be managed in an environment where only a small number of appropriate patients are able to attend for face-to-face consultations. In view of the likely continuance of social distancing it is recognised that the secondary care setting will also be returning to normal service in a gradual manner hence there is a need to continue to ensure that patients with complex disease are referred appropriately and that secondary care teams maximise the use of available facilities.

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

Clinicians vetting referrals already have the requisite clinical skills to prioritise the cases as they are referred but they should be provided with the appropriate tools and training to maximise distance consultations.

The triage for specific problems can be summarised by the following flow charts

<table>
<tr><th colspan="5">Solitary ulceration or swelling of the oral mucosa or swelling of the jawbones that has persisted for at least 2 weeks</th></tr>
<tr><td colspan="5">Is there a likely local physical cause?</td></tr>
<tr><td colspan="2">Yes
Remove cause as best possible (eg dressing of tooth) without the need to employ an aerosol generating method
Advise use of adhesive oral paste (eg Orabase) to be used on a prn basis
Advise use of a topical analgesic agent (eg benzydamine HCl (Difflam) placed on areas of discomfort in a prn basis.
Patient call back if no improvement after 5 days</td><td colspan="3">No
Assess the quality and site of the pain:
Advise use of adhesive oral paste (eg Orabase) to be used on a prn basis
Advise use of a topical analgesic agent (eg benzydamine HCl (Difflam) placed on areas of discomfort in a prn basis.
Patient call back if no improvement after 5 days</td></tr>
<tr><td>Symptoms/signs not changed
Refer to ‘2WW H&N pathway’ if solitary ulcer or Oral Medicine if cancer not suspected</td><td>If symptoms reduce/resolve no further intervention</td><td>If the symptoms or signs persist
Refer to ‘2WW H&N pathway’ if solitary ulcer or Oral Medicine if cancer not suspected</td><td>If the symptoms or reported signs worsen
Refer to ‘2WW H&N pathway’ if solitary ulcer or Oral Medicine if cancer not suspected</td><td>If symptoms resolve no further intervention at this stage</td></tr>
</table>

Severe oral mucosal and/or gingival ulceration/blistering that has persisted and/or become widespread over 2 weeks

Is the ulceration/blistering causing difficulty with swallowing, eating or speaking?

Yes	No		
Refer to Oral Medicine service	Advise use of hydrocortisone pellets (sucked) 4 times daily Or Fluticasone or beclometasone nasal spray to areas of ulceration 3 times daily And/or Adhesive oral paste (eg Orabase) to be used on a prn basis Advise use of a topical analgesic agent (eg benzydamine HCl (Difflam) placed on areas of discomfort in a prn basis.		
	Patient call back if no improvement after 5 days		
	If the symptoms or signs persist **Refer to Oral Medicine service**	If the symptoms or reported signs worsen **Refer to Oral Medicine**	If symptoms subside, no further intervention at this stage

Acute onset loss of motor function of the face or mouth

Is there a likely local cause?

Yes	No
eg traumatic injury to mouth or face **Refer to Oral Surgery**	**Refer to Oral Medicine service**

Area of paraesthesia/anaesthesia of the trigeminal region that has no obvious local cause (eg trauma or infection)

Is there a likely local cause?

Yes	No
eg recent dental extraction, trauma, recent endodontic therapy in the region of altered sensation **Refer to Oral Surgery**	**Refer to Oral Medicine service or Oral and Maxillofacial service**

Acute swelling, or progression of pre-existent chronic swelling of a major salivary gland

Is the swelling painful?

Yes	No
1. Analgesics 2. Systemic antibiotics: Amoxicillin, Flucloxacillin or erythromycin	**1. Refer to Oral Medicine or Oral and Maxillofacial service**
Review at 5 days If symptoms resolved: no further intervention at this stage If symptoms continue or worsen: **Refer to Oral Medicine or Oral and Maxillofacial Service**	

Acute lymphadenopathy, or progression of pre-existent lymphadenopathy of the head and neck

Is there a likely dental infectious cause physical cause?

Yes		No		
Identify and provide acute care of the cause (eg drainage, extraction) Patient call back if no improvement after 5 days				
Symptoms/signs not changed **Refer to Oral Medicine, Oral Surgery or Oral and Maxillofacial service**	If symptoms reduce/resolve no further intervention at this stage but contact GDP/GMP after COVID-19 national emergency status relaxed	If the symptoms or signs persist **Refer to GP for assessment**	If the symptoms or reported signs worsen **Refer to GP for assessment**	If symptoms resolve no further intervention at this stage

Severe orofacial pain not responding to over the counter analgesics				
Can it be controlled with over the counter painkillers?				
Yes advice paracetamol (and possibly codeine based – reports of ibuprofen exacerbating COVID-19 infection)		No Assess the quality and site of the pain: 1. In the trigeminal region and 'electric shock' like 2. In the temporal or masseteric area in a patient >60 years of age		
Patient call back if no improvement in 48 hours, getting worse or swelling appears **Refer to Oral Surgery service**	If symptoms subside, no further intervention at this stage	If the symptoms are either: 1. In the trigeminal region and "electric shock" like 2. In the temporal or masseteric area in a patient >60 years of age **Refer to Oral Medicine service**	If no relevant symptoms Assess at 48 hrs If no improvement or worsening **Refer to Oral Medicine**	If symptoms subside, no further intervention at this stage

5. Treatment modality

a) Local anaesthesia

Oral mucosal biopsies are not considered to be AGPs and can therefore be undertaken when necessary using the recommended PPE. Likewise intra-lesional injections and cryotherapy can be scheduled according to urgency of need as neither these would be considered to be an AGP.

b) Inhalation sedation

Inhalation sedation is hardly ever used rarely employed by the Oral Medicine team unless they are delivery care in conjunction with Paediatric dentistry colleagues in which case the local arrangements for Paediatric dentistry should be followed.

c) Intravenous sedation

Intravenous sedation is rarely employed by the Oral Medicine team unless they are delivering care in conjunction with other specialties. Treatment with intravenous sedation can be undertaken, subject to safe staffing levels and compliance with 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 which place them at greater risk of complications arising from any subsequent infection if the oral mucosal 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

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 location within the service 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 Medicine 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, 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

These questions are the same for all dental specialties.[5]

- 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 medicine services are likely to have piloted use of one of these systems already

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 for patients with oral manifestations of systemic disease.

- British & Irish Society for Oral Medicine https://bisom.org.uk/
- British Association of Dermatology www.bad.org.uk/
- British Society of Rheumatology www.rheumatology.org.uk/ and Versus Arthritis have for information for patients with rheumatological diseases www.versusarthritis.org/about-arthritis/?gclid=EAIaIQobChMI5fHohOrT6QIVcYBQBh245QAMEAAYASAEEgKeO_D_BwE

14. Workforce issues

Undoubtedly, in the recovery phase, there will be significant workforce issues that may challenge our capacity to provide dental care for 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.

References

1. www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe
2. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/605266/Delivering_better_oral_health.pdf
3. www.sdcep.org.uk/published-guidance/covid-19-practice-recovery/
4. www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19
5. www.baos.org.uk/wp-content/uploads/2020/04/BAOS-BAOMS-Joint-Advice-re-Dom-Abuse-27-4-20.pdf

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