Oral Surgery Criteria for Central Midlands

Referrals into specialist services will be returned if they fall into the following categories:

- Routine Extraction of teeth in patients including those with controlled cardiovascular/respiratory disease, diabetes and epilepsy
- Routine extraction of teeth in patients taking oral steroid replacement therapy.
- Management of dry socket and other post-operative surgical complications that are normally be treated in primary care by the GDP
- Incomplete filled referral forms and failure to attach appropriate radiographs

Referrals for MOS Treatments that may be onwardly referred into secondary care setting for the following reasons:

- Intractable, complex, or undiagnosed facial / TMJ pain
- Facial deformity and those who may require orthognathic surgery
- Treatment of jaw tumours and significantly large cysts
- Radiological evidence of significant pathology within the mandible or maxilla
- An Oral Medicine opinion including assessment of salivary glands and associated structures.
- Treatment of patients with complex medical conditions requiring multidisciplinary medical care
- Management of patients with unstable cardiovascular disease
- Management of patients with decreased respiratory function, to the extent that the patient requires home oxygen therapy
- Patients with unstable epilepsy
- Patients with any medical condition such as liver, kidney disease that requires additional investigations / optimization, prior to extraction
- Patients with severe immune dysfunction
- Patients with unstable angina or MI < 6 month
- Patients with coagulation disorders such as haemophilia, Von Willebrands
- Patients with maxillofacial trauma

Maxillofacial Surgery Department does not provide appointments for:

- Uncomplicated extractions under LA or GA
- Patient young enough to be seen by CDS
- Unable to assess nature of referral
- No valid reason given for treatment in hospital
- Intravenous sedation service (not currently available in Leicester)
- Dental assessment service
- No relevant medical history provided

NOTE:
Lesions suspected of being cancerous should use the 2-week pathway
Maxillofacial emergencies e.g. Acute large facial swellings should be directed to A&E

Return to GDP	Primary care Oral Surgery	Secondary care
Simple extraction of teeth in otherwise healthy patient or a patient with well-controlled medical co-morbidities e.g. Well controlled hypertension, asthma, diabetes etc.	Extraction of single or multiple teeth of moderate to severe complexity e.g. brittle teeth, teeth with ankylosed, dilacerated or bulbous roots, extraction of teeth close to bridges or other irreplaceable restorative work, maxillary antrum and vital structures where extraction by an experienced clinician is required etc.	1. Extraction of single or multiple teeth of moderate to severe complexity, in those with significant medical or psychiatric co-morbidities where treatment can be provided under Local or general anaesthesia. e.g. brittle teeth, teeth with ankylosed, dilacerated or bulbous roots, extraction of teeth close to bridges or other irreplaceable restorative work where extraction by an experienced clinician is required etc., 2.Extraction of single or multiple teeth of dental phobic patients under GA (MDAS form should be filled in by patient and attached to the referral) Multiple extraction of firm teeth (involving different quadrants) under GA which otherwise would have required more than 2 LA appointments to complete.
Extraction of teeth as a part of an orthodontic treatment plan, accompanied by a copy a letter from Specialist Orthodontist (Primary or secondary care) advising on the treatment plan.		Extraction of impacted teeth associated with significantly large cystic lesions.
• Repeat RCT / apicectomy • Apicectomy on unrestorable teeth; teeth with poor periodontal support; poor coronal seal, poor post crown design or post crown recemented on several occasions.	Apicectomies limited to periodontally stable incisors, canines and premolars with recurrent apical pathology not alleviated by previous root canal therapy with satisfactory orthograde root fillings	Apicectomies limited to periodontally stable incisors, canines and premolars with recurrent apical pathology not alleviated by previous root canal therapy with satisfactory orthograde root fillings in patients with other serious medical co-morbidities (Chronic renal failure, Liver disease, Haematological malignancy, advanced cardiac

Return to GDP	Primary care Oral Surgery	Secondary care
• Apicectomies on teeth that have not previously been restored.		failure, recent or current chemotherapy etc.) where input from other secondary care specialties may or may not be required- LA or GA
	Gingivoplasties and Frenectomies	Gingivoplasties and Frenectomies
		Exposure of impacted teeth. Referral accompanied by appropriate radiographs and letter from Specialist in Orthodontic stating the preferred method of exposure.
		All suspected malignant lesions should be sent to appropriate secondary care units through the 2 week wait cancer referral pathway. This includes, referral of suspicious lumps in the neck, face and skin lesions. RMS should only be used for routine referrals.
	Simple closure of Oro-antral communication and fistulas where exploration of maxillary antrum is not indicated i.e. antral washout, curettage etc.	Repeat surgery to close the fistula, OAF closure requiring secondary antral procedures or referral to other specialist service and medically compromised patients unsuitable for treatment in a Primary care setting e.g. need for GA, rotational flap techniques or bone grafts.
		Pre-prosthetic surgical procedures
		Management of teeth with cystic or periapical lesions that require enucleation
		Management of teeth with unexplained root resorption
Simple Extraction of teeth in patients on warfarin if their INR is <4 (measured within last 72 hours	Patients referred to MOS service should have stable INR of 4 or less (Measured within the past	Extraction of single or multiple teeth of anti-coagulated patients with unstable INR and / or

Return to GDP	Primary care Oral Surgery	Secondary care
	72 Hours)	other serious medical co-morbidities (Chronic renal failure, Liver disease, Haematological malignancy, advanced cardiac failure, recent or current chemotherapy etc.) where input from other secondary care specialties may be required
Extraction of Wisdom teeth (3rd Molars) that do not satisfy the NICE guidelines, Extraction of fully erupted and uncomplicated wisdom teeth	1.Extraction of wisdom teeth (3rd molars) meeting NICE criteria and require open surgical procedure 2. Extraction of malposed wisdom teeth (3rd molars) causing mucosal trauma where expertise of an experienced practitioner is required to extract the tooth e.g. Fully erupted and Distobuccally positioned maxillary 3rd molar causing acute mucosal trauma, fully erupted mandibular 3rd molar in lingually inclined, with difficult surgical access etc.	Extraction of NICE guideline compliant, third molars in medically compromised patients, those with other associated pathology e.g. tumours or cysts, those requiring general anaesthesia and those who are having impacted third molars removed prior to orthognathic surgery.
Low risk patients – Patients on Oral bisphosphonates, IV Bisphosphonates quarterly or annually or denusumab for less than 5 years to treat osteoporosis or non-malignant bony diseases and NOT on concurrent systemic steroids (Source: NICE/SDCEP 2017) Simple extractions can be carried out by GDP's on Low risk patients	Patients taking bisphosphonates at higher risk of developing MRONJ 1.High risk patients- Patients on oral bisphosphonates, quarterly or annual IV bisphosphonates for more than 5 years to treat osteoporosis or non-malignant bone disease. 2. Patients on bisphosphonates or denusumab for any length of time along with concurrent use of systemic steroids to treat Osteoporosis or non-malignant bone disease 3. Patients on anti-resorptive and / or anti-	Extraction/s in High risk patients whether it is done by primary care MOS provider or secondary care staff, the risk of developing MRONJ is nearly the same. The assumption is, both the groups have carried out enough number of extractions to achieve expected level of surgical competency to deliver atraumatic extraction/s in these high-risk group.

Return to GDP	Primary care Oral Surgery	Secondary care
	angiogenic medication to stabilise bone in malignant disease, with a previous History of MRONJ These patients can be referred to MOS service. Following the extraction these patients should be monitored for satisfactory healing of the socket(s). If extraction socket(s) healing is delayed, even after 8 weeks, a diagnosis of MRONJ is made and patient are referred to secondary care unit. Source: NICE/SDCEP 2017	
Surgical removal of retained roots with favourable root morphology where a flap is not required to complete this surgical procedure.	1.Extraction of symptomatic supra or subgingival buried roots (soft tissue or bony) where open surgical extraction may be required 2.Extraction of supra or subgingival buried roots (soft tissue or bony) that are likely to become symptomatic where open surgical extraction may be required e.g. extraction of buried root before making a denture, dental implants, bridges or starting fixed orthodontic treatment etc.	
	• Teeth with abnormal root morphology likely to compromise ease of extraction by GDP. • Teeth with internal or external root resorption • Unfavourably fractured teeth • Teeth/Roots near anatomical structures such as mental foramen, inferior dental canal, maxillary sinus or heavily restored bridge work • Teeth that are impacted and / or malposed e.g.:	

Return to GDP	Primary care Oral Surgery	Secondary care
	partially erupted and lingually impacted mandibular premolars etc.	
	• Root amputations or coronectomies	
Incision and drainage of simple, small abscesses, without systemic symptoms.		
Extraction of periodontally involved teeth	Surgical removal of grossly decayed teeth	
Conservative management of TMJ dysfunction to include supportive patient education such as encouraging relaxation, education against behaviours such as clenching and grinding and recommending a softer diet; pharmacological pain control such as NSAID where this is not contra-indicated; recommending remedial jaw exercises and fabrication of night guard.		Temporo-mandibular joint problems resistant to conservative measures provided by the GDP
Management of minor trauma including re-implantation of avulsed teeth		Maxillofacial Trauma, and emergencies such as significant oro-facial infection **(such cases should be referred to A&E)**
Sedation cases where an Indicator of Sedation Needs (IOSN) form has not been completed	Patients requiring treatment under sedation with a MDAS anxiety level of 12 and above. The MOS specialist will assess the patient and decide if onward referral to a secondary centre is required for General Anaesthesia	Patients requiring general anaesthesia where there is a full justification of why treatment cannot be provided by any other means.