

REFERRAL POLICY AND PARAMETERS OF CARE

This document sets out guidelines to define a framework for the provision of periodontal care by members of the dental team, and to provide guidelines for appropriate referral of patients in need of periodontal treatment in a secondary care setting. It is based on an earlier version of this policy from 2002 and has been substantially updated in 2011.

Referral of patients with periodontal problems to either specialist practitioners or hospital consultants depends on several factors including-

1. The severity of disease and complexity of treatment required.
2. The patient's desire to see a specialist or undergo specialist treatment.
3. The GDP's knowledge, experience and training to treat patients with a range of periodontal problems.
4. The presence of other complicating factors such as a patient's medical history or other co-morbidity.

The referral policy here is based on a simple assessment of case complexity using the Basic Periodontal Examination (BPE) and is intended as a guideline for clinical practice. Further background information is available, including detail of BPE-based periodontal screening and related periodontal assessments, in the associated BSP policy document – “The Basic Periodontal Examination.”

Parameters of Care

- It is the responsibility of the dentist to monitor/screen patients regularly for the presence of periodontal diseases, including the use of relevant radiographs, to make a diagnosis and institute a treatment plan with defined therapeutic goals. On occasions a GDP may wish to refer a patient for a specialist opinion at an early stage to assist with diagnosis and treatment planning.
- All periodontal assessments should be recorded in patients' clinical records. Where treatment has been previously provided, outcome assessments should similarly be recorded,
- The findings of every periodontal examination must be presented to the patient. Treatment options and consequences of no treatment should be explained.
- Even where referral for further treatment is considered, initial therapy including oral hygiene instruction and supra and subgingival scaling should normally be carried out in the primary care setting by the GDP or dental hygienist.
- Control of other modifiable risk factors where indicated, particularly smoking, should also be instigated by the GDP, if necessary by referral to smoking cessation services.
- In certain cases, for example because of the health of the patient, non-compliance, or the severity of the disease, treatment to simply prevent the progression of disease may be appropriate. In these cases initial therapy may become the end point.
- The GDP should organise suitable maintenance care at appropriate time intervals for treated patients, if possible with dental hygienist/dental therapist input. This is the case irrespective of whether the active treatment was provided in a primary or secondary care setting.

As a guideline for referral policy using Periodontal Treatment Assessment criteria, **Complexity 1** cases should generally be treated in general dental practice, **Complexity 2** cases may either be treated by the GDP or referred; **Complexity 3** cases should mostly be referred. It is worthy of note that sometimes apparently simple periodontal treatment may have to be delivered by Specialists as part of a more complex integrated treatment strategy. Equally, patients falling into the **Complexity 3** category may not necessarily require care from a specialist. Initial nonsurgical treatment of cases should generally be carried out in general practice.

Periodontal Treatment Assessment		P E R I O D O N T A L T R E A T M E N T A S S E S S M E N T
Based upon the Basic Periodontal Examination (BPE) Criteria :		
• BPE Score 1 - 3 in any sextant	= Complexity 1	
• BPE Score of 4 in any sextant • Surgery involving the periodontal tissues	= Complexity 2	
• Patients with BPE scores of 4 in at least one sextant, and one or more of the following factors : ○ Concurrent medical factor directly affecting the periodontal tissues, (eg diabetes, medication, etc); ○ Complicating root morphologies / anatomical factors; ○ Non-response to previous optimally carried out treatment • Diagnosis of aggressive periodontitis as assessed either by severity of disease for age or based on rapid rate of periodontal breakdown; • Patients requiring surgical procedures involving tissue augmentation or regeneration, including surgical management of mucogingival problems; • Patients requiring surgery involving bone removal (eg crown lengthening); • Patients requiring surgery associated with osseointegrated implants.	= Complexity 3	
The presence of a relevant modifying factor increases the complexity by 1 increment, and is not cumulative :		
Modifying Factors that are Relevant to Periodontal Treatment • Co-ordinated medical or dental multi-disciplinary care • Medical history that significantly affects clinical management (see below) • Regular tobacco smoking • Special needs for the acceptance or provision of dental treatment. • Concurrent mucogingival disease (e.g. erosive lichen planus)		
Medical History that Significantly Affects Clinical Management • Patients with a history of head / neck radiotherapy or intravenous bisphosphonate therapy. • Patients who are significantly immunocompromised or immunosuppressed. • Patients with a significant bleeding dyscrasia / disorder. ▪ Patients with a potential drug interaction.		

The index of treatment needs for periodontal treatment assessment is based on the most widely used practitioner oriented Basic Periodontal Examination (BPE) as devised by the British Society of Periodontology. It sets complexity codes in a simplistic manner with the addition of a list of modifying factors that are relevant to periodontal treatment and an outline of medical histories that significantly affect clinical management. It is strictly a complexity assessment and does not address either the motivational aspects of treatment or the prioritisation of treatment.

Nevertheless it is a very useful tool not only for providing guidelines of complexity but also for indicating according to complexity where treatment may be carried out.

As with all treatment involving treatment teams, the long term success of these care pathways depend on good communication between the clinicians involved to ensure consistency of treatment objectives and appropriate long term follow up.