For Dentists and Other Dental Professionals:

Dental Screening Program for Patients Who May Need Hematopoietic Stem Cell Transplantation (HSCT)

Dear Dental Care Provider,

Thank you for your contribution to this screening program. Please review and complete all the attached materials for your patient who is a prospective candidate for **hematopoietic stem cell transplantation (HSCT)**.

PLEASE BE SURE TO SUBMIT THE FOLLOWING:

- ☐ Dental Evaluation Form (see final 2 pages of this document)
- ☐ Dental Radiographs (instructions below)

HOW TO SEND THE DENTAL EVALUATION FORM

- Email your completed report to: bwhoralmedicine@partners.org
- Please use the following format for the subject header: **HSCT, Smith, J 1.1.1955** – this is the **name of service** (HSCT), the **patient's last name** (Smith), the **patient's first name initial** (J) and **date of birth** (1.1.1955)

OR

- Fax your completed report to **617-264-6312**.

HOW TO SEND DENTAL RADIOGRAPHS

A) **Digital radiographs:**

- Email to: bwhoralmedicine@partners.org
- Please use the following format for the subject header: **HSCT, Smith, J 1.1.1955** – this is the **name of service** (HSCT), the **patient's last name** (Smith), the **patient's first name initial** (J) and **date of birth** (1.1.1955).

B) **Film:**

- Send by OVERNIGHT MAIL to: Division of Oral Medicine and Dentistry, Brigham and Women's Hospital, ATTN: HSCT Coordinator, 75 Francis St., Boston, MA 02115
- **Attention:** If you send film, please keep the originals as these will not be returned.

Please contact us at bwhoralmedicine@partners.org or **617-732-6974** if you have any questions for the Oral Medicine specialists regarding dental treatment issues or completion of the Dental Evaluation Form. For all other issues, please ask the patient for his or her oncologist's contact information.

Thank you,

The Division of Oral Medicine and Dentistry Providers
Brigham and Women's Hospital, 75 Francis St., Boston, MA
617-732-6974

INSTRUCTIONS FOR DENTAL EVALUATION OF PATIENTS UNDERGOING HEMATOPOIETIC STEM CELL TRANSPLANTATION

Your patient is presenting to you for a dental evaluation in preparation for hematopoietic stem cell transplantation (HSCT), a potentially life-saving procedure used to treat cancer and certain non-cancerous blood disorders. Good oral health may reduce complications during and after HSCT.

During admission for HSCT, your patient's neutrophil count will fall, placing him/her at risk for a life-threatening infection/septicemia. Therefore, elimination of all potential sources of oral infection is an important aspect of preparation for HSCT and we ask for your assistance in achieving this.

Please give your patient priority for an appointment to expedite dental care. In some cases, you may have only one to two weeks in which to complete your evaluation and treatment.

You should proceed with the radiographs and full evaluation even if the counts are low.
If the platelet count is less than 50,000, or if the absolute neutrophil count (ANC) is less than 1,000, consult with your patient's oncologist or our oral medicine specialists before commencing dental treatment. Your patient should be able to tell you what his/her counts are.

Please read the following instructions carefully. If you have questions regarding dental issues or the dental evaluation form, please call the Division of Oral Medicine and Dentistry at 617-732-6974. For medically related questions, please ask the patient for his or her oncologist's contact information.

PROCEDURES

1) Perform a complete dental evaluation, including full mouth periodontal charting and sufficient radiographs to:
    a. Diagnose caries
    b. Diagnose periodontal disease
    c. Diagnose periapical pathology
    d. Visualize partial soft tissue impacted 3rd molars

2) Complete the necessary dental treatment.

3) Send your Dental Evaluation Form to BWH Division of Oral Medicine and Dentistry.

RADIOGRAPH GUIDELINES

The radiographs should be current (within 6 months) and of high diagnostic quality. Please ensure that the radiographic examination is sufficient in your clinical judgment to diagnose the conditions listed above. These may include any/all or a combination of the following:

- Full mouth series
- Panoramic radiograph with bitewings
- Panoramic radiograph with select periapical radiographs (as many as clinically indicated)

RESTORATIVE TREATMENT

- Restore all carious teeth.
- If caries extends to the pulp, consider endodontic therapy or extraction.
- Whenever possible, consider amalgam restorations rather than composite restorations for posterior teeth or Class V restorations.
- Although your patient may receive between 1200-1400 cGy of total body radiation, there is no need to fabricate fluoride trays.

PERIODONTAL TREATMENT

- Your patient will need a dental prophylaxis if s/he has not had one within the last three months
- Areas with slight (mild) or moderate periodontal disease should receive deep scaling and root planing

	Slight (Mild)	**Moderate**	**Severe (Advanced)**
Probing depths	>3 and <5 mm	≥5 mm and ≤7 mm	≥ 7 mm
Bleeding on probing	Yes	Yes	Yes
Radiographic bone loss	Up to 15% root length or ≥2mm and ≤3mm	16%-30% or >3mm and ≤ 5 mm	> 30% or >5 mm
Clinical attachment loss	1-2 mm	3-4 mm	≥5 mm

J Periodontol 2015: American Academy of Periodontology Task Force Report on the Update to the 1999 Classification of Periodontal Diseases and Conditions

- Teeth exhibiting severe (advanced) periodontitis should be extracted
- During your patient's hospital stay, which typically lasts 2-4 weeks, s/he will be using a soft toothbrush and rinsing with chlorhexidine

ENDODONTIC TREATMENT

- All teeth that have received direct/indirect pulp caps or have large restorations should be tested for vitality and endodontically treated or extracted if non-vital
- Teeth that are *symptomatic* after endodontic therapy or with sinus tracts need careful reevaluation and may require retreatment, surgery, or extraction
- Teeth with persistent periapical radiolucency (usually < 5 mm) that are *asymptomatic* after endodontic therapy and without sinus tracts *do not require treatment*

ORAL SURGERY

- All grossly decayed and non-restorable teeth should be extracted
- All teeth with severe periodontal disease should be extracted
- Adequate alveoloplasty and primary closure should be performed (when possible)
- Chlorhexidine rinse and prophylactic antibiotics may be considered for one week following extractions
- Allow at least 7 days for healing prior to HSCT hospital admission

Third molars

- Third molars that are partially erupted and that have been symptomatic in the past (e.g., pericoronitis) should be extracted
- Fully impacted (soft tissue or bone) asymptomatic third molars need not be extracted

Areas of trauma

- Identify and eliminate all sources of oral trauma and irritation, such as sharp edges of teeth, ill-fitting dentures, orthodontic brackets, and other appliances

Bisphosphonates and patients with multiple myeloma

- If your patient has a diagnosis of multiple myeloma, please ask her/him if s/he is or was on bisphosphonate therapy (e.g., monthly zoledronic acid), which places the patient at risk for developing jaw osteonecrosis
- Perform surgical procedures as atraumatically as possible
- Following a dental extraction, gently curette the socket and irrigate with saline.
- Prescribe antibiotic therapy (e.g., amoxicillin 500 mg TID or clindamycin 300 mg TID) for at least two weeks following the surgical procedure or until the soft tissue wound has closed
- Prescribe chlorhexidine rinse
- Re-evaluate the extraction site in approximately two weeks to ensure closure of the gingiva and adequate healing, with additional follow-up scheduled as needed

Please help expedite your patient's dental treatment as any delays may cause a postponement of their transplant.

Thank you for your help preparing your patient for cancer therapy. If you have any questions, please do not hesitate to call us at 617-732-6974.

DENTAL EVALUATION FORM
(P1 OF 2)

Please complete this form

Patient's Name _____

Date of Birth (DD/MM/YYYY) _____

Examiner's Name _____

Examiner's Address _____

Examiner's Phone No. (include area code) _____

Examiner's Email _____

Patient's cancer diagnosis_____

History of pericoronitis: Please comment if you circle Y.

Y N _____

Date of enclosed radiographs _____

Intra-oral examination:

Y N Symptomatic teeth _____

Y N Vitality testing (any tooth with large restorations)
_____

Y N Areas of suppuration/fistulae/sinus tract _____

Periodontal disease classification (select one): Mild Moderate Severe

Radiographic findings:
Presence of apical lucencies: _____

Other findings (clinical, mucosal and radiographic):
_____

DENTAL EVALUATION FORM (P2 OF 2)

DENTAL TREATMENT PLAN

Tooth	Caries	Severe Periodontal disease	Partial Soft tissue impacted	Other	Completed Treatment
1					
2					
3					
4					
5					
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31					
32					
Other					

- ☐ Prophylaxis completed (date): _____
- ☐ Scaling root planning completed (if applicable): _____

Other comments _____

_____

Signature of examiner/Date