Dental Clearance Checklist for Head and Neck Cancer Patients

- Dental Disease Factors
  - *condition of the current dentition*
    - **tooth condition**
      - mild to moderate dental caries: restore with composite or GI
      - moderate dental caries: consider root canal pretreatment (if time allows)
      - severe dental caries: extract
    - **periapical infection:** root canal with crown or extract
    - **periodontal bone loss:** immediate perio therapy or extract
      - perio conditions with POOR prognosis—> extraction
        - teeth with > 5mm perio pockets
        - teeth with furcation involvement
        - teeth with perio abscesses
        - teeth with moderate to severe mobility
    - **fractured teeth**: extract
  - *dental compliance of the patient* (home care and in-office care)
  - *maxillary vs mandibular teeth* (must be more aggressive/proactive in mandible)
- Removable Prosthodontics
  - Lingual and Palatal Tori: if fully dentate do not remove, if partially dentate then consider removal or lingual plate RPD, if completely edentulous or planned must remove all tori prior to cancer treatment
- Completely Edentulous patients: assess for root tips, impacted teeth with infection or partially impacted teeth with any exposure into the oral cavity
- **Timing and priority of pre-radiation treatment:**
  - **1. extractions 2. root canals & perio 3. dental fillings 4. dental cleaning**
- Dental Maintenance: topical fluoride, oral hygiene instructions, professional cleaning every 3-4 months with regular follow-ups, anti-plaque mouthwash, diet low in sugars with reduced snacking
  - Topical Fluoride: 1% SODIUM FLUORIDE or 0.4% stannous fluoride gel
    - APF acidulated phosphate fluorides are *not recommended*
  - Dry Mouth Products: mouthwash (biotene, cloSYS), tablets (XyliMelts), gel (GC Dry Mouth Gel)

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HEAD AND NECK RADIATION ONCOLOGY DENTAL CONSULT

We have performed a comprehensive dental examination on _____ *(patient)*

with DOB of _____/_____/_____. Date of exam was _____/_____/_____.

Due to the risk of **osteoradionecrosis of the jaw** seen with this treatment, we ask the patient's dentist to provide the following dental services:

1. Detailed baseline dental exam to include:
   a. Panoramic film, full mouth series or comb beam CT for baseline assessment/prognosis of dentition.
   b. Comprehensive periodontal evaluation.
   c. Edentulous patients should receive a dental assessment including panoramic radiograph to screen for retained teeth and occult lesions not clinically evident.
2. Extract all unrestorable teeth or any tooth with a poor or hopeless prognosis
   Consider these guidelines for dental extractions:
   a. Full mouth extractions may be indicated in patients who cannot or will not commit to good dental health care practices.
   b. Extractions are indicated in areas of severe periodontal bone loss, whether localized or generalized. Proper periodontal treatment generally involves too much time and variability to predictably provide the desired pre-therapy state of stable oral health.
   c. Extraction would be indicated for any teeth with periapical pathology that cannot receive timely, appropriate endodontic therapy.
3. Assess appliances (complete/partial dentures) for proper fit. Remove/reduce sources of irritation or friction.
4. Oral Hygiene program: Instruct on proper brushing, flossing, and frequency of care.
5. Return to office appointments for oral health monitoring and assessment of oral hygiene compliance:
   a. Schedule return visits at 3 to 6 month frequency as is most appropriate for this patient.
   b. Repeat films if a problematic situation exists which the dentist feels is appropriate to monitor.
   c. Reassess for good appliance fit
   d. Assess compliance with oral hygiene program

TO BE COMPLETED BY THE DENTIST PERFORMING THE BASELINE EXAM:

Patient has adequate/stable oral health and may initiate radiation therapy ☐

Patient will require extraction/further invasive procedure; following procedure wait 2-4 weeks until the healing process is completed to initiate radiation therapy ☐

Scheduled treatment date(s): _____

Dental Provider's Signature: _____ Date: _____

Dental Provider's Name (*print*): _____ Ph#: _____

PATIENT'S RADIATION ONCOLOGIST: _____

PLEASE FAX CLEARANCE FORM BACK TO RADIATION ONCOLOGY ALONG WITH ANY DENTAL REPORTS.