Contributors: Dr FM Fong, Dr J Davies, Dr JM Fearne & Prof KJ Pasi *(Royal London Hospital, UK)*

Barts Health NHS

NHS Trust

DENTAL CARE PATHWAY FOR CHILDREN WITH INHERITED BLEEDING DISORDERS

Introduction

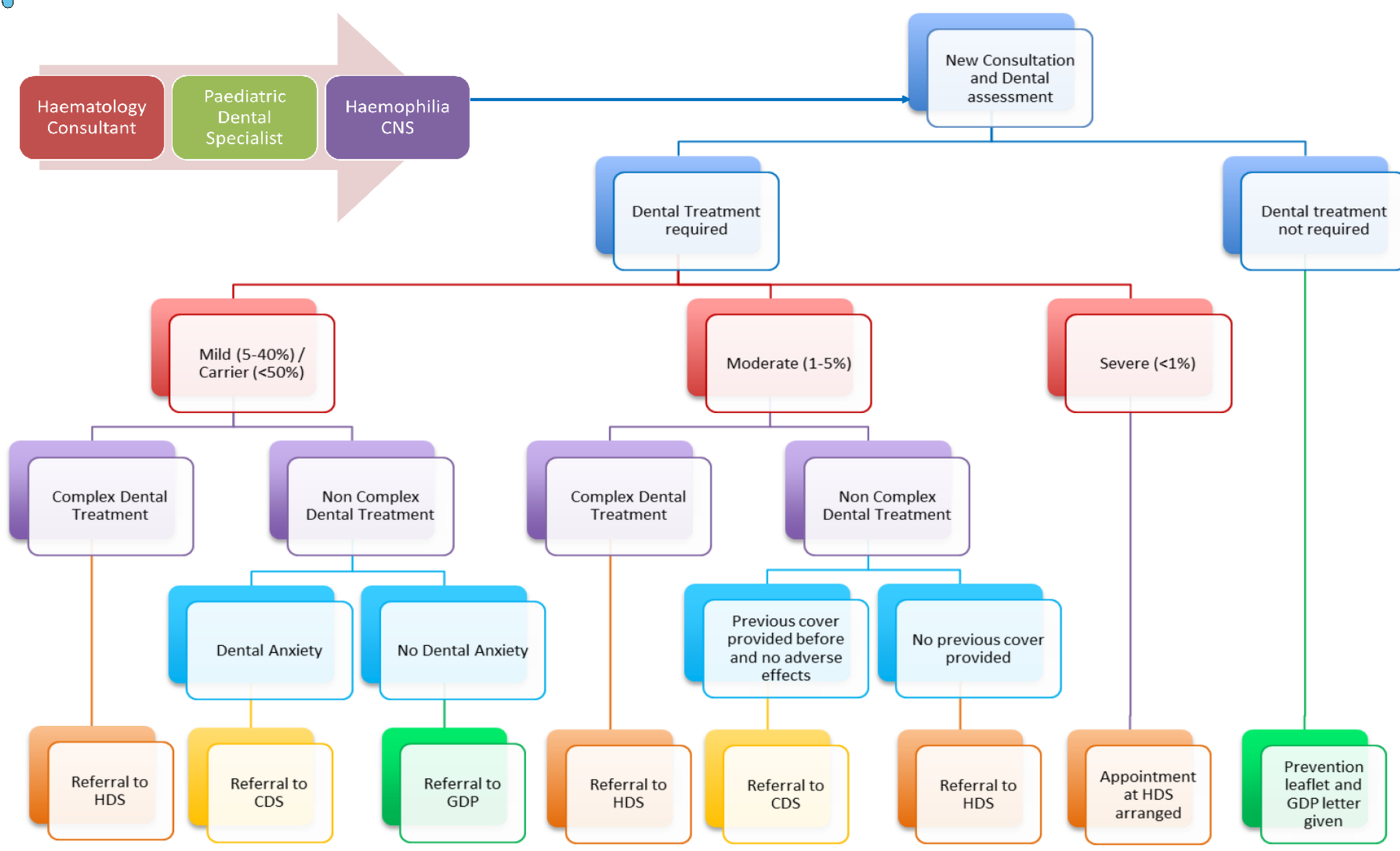
The Royal London Hospital is a major referral centre for over 250 children with inherited bleeding disorders. Dental disease can place a further burden on these children particularly if teeth require extraction. Due to an increasing demand on the paediatric hospital dental service (HDS), a new paediatric dental care pathway has been established based on work by Kalsi *et al*[1].

Current guidelines

The 2013 guidelines[2] state:

- Inferior dental block and lingual infiltration require factor cover.
- Buccal infiltrations, intra-papillary and intra-ligamentary injections do not require factor cover.
- Moderate (2-5%) to severe (<1%) haemophilia patients require all dental treatment to be carried out in the HDS with a specialist dental unit.
- Mild haemophilia (5-40%) or carriers with less 50% factor percentage can be treated in primary care setting with their general dental practitioner (GDP) or community dental service (CDS). They should also be reviewed every two years by the specialist dental team at the haemophilia centre.

Our New Care Pathway



A Specialist in Paediatric Dentistry attends the monthly Paediatric Haematology clinics. Emphasis is placed on the importance of prevention and preventive advice is given verbally and in the form of a patient information leaflet which highlights the key points from the Delivering Better Oral Health guidance[3].

0-3 years old	3-6 years old	6+ years old
• Brush 2 times a daily as soon as teeth erupt • Supervise and assist brushing • Smear of toothpaste containing no less than 1000ppm fluoride • Frequency and amounts of sugars at mealtimes and no more than 4 daily • Sugar free medicine should be recommended • No sugar should be added to weaning foods • Breast feeding provides best nutrition for babies • Introduce cup at 6 months & wean off bottle at age of 1 year	• Brush last thing at night and on one other occasion • Supervise and assist brushing • Pea sized amount of toothpaste containing 1350-1500ppm fluoride • Frequency and amounts of sugars at mealtimes and no more than 4 daily • Sugar free medicine should be recommended • Spit after brushing and do not rinse	• Brush twice daily • Fluoridated toothpaste over 1350ppm fluoride • Frequency and amounts of sugars at mealtimes and no more than 4 daily • Sugar free medicine should be recommended • Spit after brushing and do not rinse

Haematologist

- Determines severity of bleeding risk
  - Mild (5-40%) or Carrier (<50%)
  - Moderate (1-5%)
  - Severe (<1%)

Dentist

- Determines degree of invasive treatment required
  - Minimal: Dental fillings without local anaesthetic or with infiltration
  - Moderate: Fillings requiring ID block or involving pulp
  - Severe: Dental extractions, subgingival dental scaling and dental surgery

Consultation between the haematologist and the dentist will determine whether treatment can be provided by their local dentist or whether treatment should be undertaken in a secondary care hospital setting as suggested in the diagram above.

A letter to the GDP is given to the patient to hand deliver with full details of treatment, emergency contact details and appropriate cover if required. Liaison of GDPs with both haematology and dental services is actively encouraged to support provision of dental care within primary care.

Hospital dental care

The date of the dental visits and the haemostatic cover are requested via our electronic messaging system. This message is directly linked to their electronic patient record so that it is accessible to all clinicians involved in their care. The haemophilia clinical nurse specialist (CNS) will arrange the appropriate cover prior to their appointment.

Discussion

The pathway is based on the importance of a structured consultation process involving dental, medical and nursing staff. This pathway encourages active involvement of the patients' local dentist, which improves access to dental care, increased local involvement and confidence of GDPs. It is also more convenient to the patients to be seen more locally to their residence, which will help to minimise their absence from school for medical and dental care. This helps to provide a more patient orientated service and allows the secondary hospital based dental services to focus on more complex and demanding cases.

References

1. Kalsi, H. Nanayakkara, L. Pasi, K.J. Bowles, L. Hart, P. (2012) Access to primary dental care for patients with inherited bleeding disorders. *Haemophilia*. **18**(4):510-515
2. Anderson, J.A.M. Brewer, A. Creagh, D. Hook, S. Mainwaring, J. McKernan, A. Yee, T.T. Yeung, C.A. (2013) Guidance on the dental management of patients with haemophilia and congenital bleeding disorders. *British Dental Journal*. 215:497-504
3. Department of Health & The British Association for the Study of Community Dentistry. *Delivering Better Oral Health: An evidence-based toolkit for prevention (Second Edition)*, GR12231. London; 2009.

Barts Health NHS Trust: Newham University Hospital, The London Chest Hospital, The Royal London Hospital, St Bartholomew's Hospital and Whipps Cross University Hospital.