

Dental Clearance Program for Patients Who Are Scheduled for Hematopoietic Stem Cell Transplantation (HSCT)

Dear Dental Care Provider,

Your patient is a candidate for **hematopoietic stem cell transplantation (HSCT)**. Please evaluate your patient and complete any necessary dental work. Thereafter, complete and submit the dental clearance form so that your patient is cleared from an oral health standpoint to receive a HSCT. Thank you for your contribution to this important clearance program.

PLEASE BE SURE TO SUBMIT THE FOLLOWING:

- Dental Clearance Form (see last page of this document)
- Dental Radiographs (instructions below)

HOW TO SEND THE DENTAL CLEARANCE FORM AND RADIOGRAPHS

- Email your completed form and radiographs (if taken as digital) to: bwhoralmedicine@partners.org
- Please encrypt the email and use the following format for the subject header:
 - 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) – e.g. **HSCT, Smith, J 1.1.1955**
- Fax your completed form to 617-264-6312

OR

Please contact the oral medicine team at bwhoralmedicine@partners.org or **617-732-6974** if you have any questions regarding the dental clearance process. For all other questions, please contact the oncology team.

Thank you,

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

INSTRUCTIONS FOR DENTAL EVALUATION OF PATIENTS WHO ARE PLANNED FOR HEMATOPOIETIC STEM CELL TRANSPLANTATION

Your patient is presenting to you for a dental evaluation in preparation for hematopoietic stem cell transplantation (HSCT). Good oral health may reduce complications during and after HSCT.

During admission for HSCT, your patient's neutrophil count will fall, placing them at risk for a life-threatening infection/septicemia. Therefore, elimination of all potential sources of oral infection is an important step in preparing patients for HSCT, and we would like your assistance in achieving this.

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

You should proceed with a full evaluation and if appropriate, radiographs 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 team before starting any invasive dental treatment. Your patient should be able to tell you what their counts are.

PROCEDURES

- 1) Perform a complete dental evaluation, including radiographs as you deem necessary.
- 2) It is suggested that you take radiographs on teeth with any previous dental treatment such as restorations, crowns, and endodontic therapies even if the teeth are asymptomatic.
- 3) Complete the necessary dental treatment.
- 4) Send your completed Dental Clearance Form to the Oral Medicine and Dentistry team.

RESTORATIVE/PROSTHODONTIC GUIDELINES

- Consider removing all carious lesions extending beyond the dentin-enamel junction and restore with definitive or solid temporary materials. If time does not permit, definitive restoration can be postponed until after HSCT.
- If caries extends to the pulp, consider endodontic therapy or extraction.
- Remove any sharp edges from defective restorations/prosthesis or cracked/chipped teeth.
- Dental prosthesis (fixed or removal): Ensure that there is no sharp edge or rough surface which may potentially traumatize surrounding soft tissues.
- Definitive prosthodontic treatment can be postponed until after HSCT (e.g. placing crowns for endodontically treated teeth).

PERIODONTAL GUIDELINES

- Provide a dental prophylaxis and/or deep scaling and root planing if your patient has not had one within 3-6 months.
- Consider extracting teeth exhibiting severe (advanced) periodontitis with 2+ to 3+ mobility.

ENDODONTIC GUIDELINES

- All teeth that are known to have received direct/indirect pulp caps or with large restorations should be reevaluated for vitality and treated as necessary.
- Teeth that are *symptomatic* after endodontic therapy or with sinus tracts need careful reevaluation and treatment as necessary.
- Endodontically treated teeth with persistent but stable periapical radiolucency <5mm that are asymptomatic usually do not become symptomatic during HSCT, and therefore, may not require treatment prior to HSCT.

ORAL SURGERY GUIDELINES

- Consider extracting all teeth with
 - gross decay that is non-restorable
 - severe periodontal disease with 2+ to 3+ mobility, and/or
 - dental abscesses not otherwise planned for endodontic therapy
- Adequate alveoloplasty and primary closure may prevent complications during HSCT.
- Chlorhexidine rinse and prophylactic antibiotics may be considered for one week following extractions.
- Allow adequate healing time (usually at least 7 days) prior to HSCT hospital admission.
- Consider extracting third molars that are partially erupted and that have been symptomatic in the past. However, fully impacted (soft tissue or bone) asymptomatic third molars are unlikely to require extraction prior to HSCT.

ORTHODONTIC GUIDELINES

- Consider removing orthodontic devices (e.g. brackets, retainer, etc.) as they may be sources of soft tissue trauma during HSCT.

Please help expedite your patient's dental treatment as any delays may cause a postponement of their transplant. If you are unable or unwilling to perform this evaluation, please return the letter below immediately to:

The Division of Oral Medicine and Dentistry at Brigham and Women's Hospital

Email: bwhoralmedicine@partners.org

Fax 617-264-6312

Thank you for your help preparing your patient for cancer therapy. We want to thank you in advance for your important contribution to your patient's health and safety.



DENTAL CLEARANCE FORM

Please complete this form and send to the Oral Medicine and Dentistry team

Patient's Name _____ Patient's Date of Birth (MM/DD/YYYY) _____

Dentist's Name _____

Dentist's Address _____

Dentist's Email/Phone Number _____

Date of Last Scaling/Root Planing and/or Prophylaxis _____

Dental Treatments Rendered for the Clearance			Teeth Number
Y	N	Restorative therapy	_____
Y	N	Surgical therapy/Extractions	_____
Y	N	Endodontic therapy	_____
Y	N	Others (Please Explain)	_____

Other comments: _____

Please check and sign if dental clearance is complete

Signature of Dentist/Date

Please check and explain if you are UNABLE to provide the dental clearance and return this to us by email or fax as soon as possible.

Explanation: _____