DANA-FARBER/BRIGHAM AND WOMEN'S

CANCER CENTER

Division of Oral Medicine and Dentistry, Brigham and Women's Hospital

Dear Provider,

Please review and complete all the attached materials for your patient who is a prospective candidate for **head and neck (H&N) radiation therapy**.

PLEASE ENSURE YOU HAVE ENCLOSED THE FOLLOWING:

- ☐ Completed 2-page Evaluation Form
- ☐ Completed 1-page Treatment Plan
- ☐ Complete full mouth radiographs **ONLY**
- ☐ Panoramic radiograph (if indicated)

DIRECTIONS ON HOW TO SEND EVALUATION FORM, TREATMENT PLAN AND DENTAL FILMS:

A) If you use digital films:

- Email your completed report and films to: bwhoralmedicine@partners.org. Please use the following format for the subject header: **H&N, Smith, J 1.1.1955** – this is the name of service (H&N), 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 and Email films to bwhoralmedicine@partners.org

B) If you use non-digital films:

- Send non-digital films BY OVERNIGHT MAIL to: Division of Oral Medicine and Dentistry, Brigham and Women's Hospital, Attn: BMT/H&N Coordinator, 75 Francis Street, Boston, MA 02115, AND
- Email your completed report to: bwhoralmedicine@partners.org. Please use the following format for the subject header: **H&N, Smith, J 1.1.1955** – this is the name of service (H&N), 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.
- **Attention:** Please keep a copy of the radiographs for your files and send us the originals; we will not be returning the films to you.

Please contact us at bwhoralmedicine@partners.org or 617-732-6974 if you have any questions for the Oral Medicine specialists regarding dental issues or the dental evaluation form. For all other issues, please ask the patient for their oncologist's contact information. **Do not wait until the dental treatment is completed before forwarding the information.** Any delay in returning this information may cause a postponement of the cancer treatment.

Thank you, The Division of Oral Medicine Providers

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INSTRUCTIONS FOR DENTAL EVALUATION OF PATIENTS UNDERGOING HEAD AND NECK (H&N) CANCER THERAPY

Your patient is presenting to you for a dental evaluation because he/she has been diagnosed with a head and neck cancer. The treatment may involve surgery, chemotherapy or radiation therapy. It is essential that your patient receive a comprehensive dental evaluation in preparation for cancer therapy. Good oral health may minimize complications during and after treatments.

Please give your patient priority for an appointment to expedite dental care. There may be a limited amount of time available in order to complete any necessary dental care.

Perform a complete dental evaluation, full mouth periodontal charting and obtain a full mouth series of radiographs. Complete the 2-page evaluation from and 1-page treatment plan.

- **The radiographs must not be more than 6 months old. If third molars are present, please also obtain a panoramic film.**
- **A panoramic film alone in a dentate patient is not sufficient for this evaluation.**
- **If the patient is edentulous, a panoramic film should be obtained to rule out retained root tips or any bone lesions.**

If necessary, one of the Oral Medicine providers will contact you regarding your patient's treatment plan. It is critical that your material be forwarded to us as soon as possible. **Do not wait until dental treatment is completed before forwarding the information.** Any delay in dental treatment may cause a postponement of the cancer treatment.

The proposed dental treatment may be affected by your patient's specific medical diagnosis and proposed medical treatment. In some instances, dental treatment may need to be conservative and in other instances it may need to be more aggressive. Some general guidelines for dental preparation prior to head and neck cancer therapy include the following:

Preventive therapy

- Fabricate custom fluoride gel-applicator trays for your patient to use daily. If patient is unable to use trays, have them apply the gel with a toothbrush without rinsing afterwards .
- Prescribe a 1.1% neutral pH sodium fluoride gel or a 0.4% unflavored stannous fluoride gel or Prevident 5000 Plus™ 1.1% sodium fluoride prescription toothpaste to brush on teeth BID.
- Reinforce oral hygiene regimen:
  - Brush 3 times daily
  - Floss daily
  - Apply fluoride trays 30 minutes daily

Restorative treatment

- Restore all carious, severely worn, and fractured teeth.

Periodontal treatment

- Your patient will need a dental prophylaxis if s/he has not had one within the last three months.
- Areas with periodontal pocketing of > 4-5 mm should receive deep scaling and curettage.

Endodontic therapy

- Teeth that are symptomatic after endodontic therapy or with sinus tracts need careful reevaluation and may require retreatment, surgery, or extraction.
- However, teeth that are asymptomatic after endodontic therapy with < 5 mm periapical pathology and without sinus tracts do not require treatment. Please contact us if you have any questions about this.
- All teeth that have received direct/indirect pulp caps or have large restorations should be vitality tested.

Oral surgery

- All grossly decayed and non-restorable teeth should be extracted.
- Perform adequate alveoplasty and primary closure.
- Chlorhexidine rinse and prophylactic antibiotics may be considered for one week following extractions.
- Allow at least 7 days for healing prior to the initiation of radiation.
- Conduct prosthetic surgery before treatment, since elective surgical procedures are contraindicated on irradiated bone.

Third molars

- Third molars that are partially erupted should be extracted if they have been symptomatic in the past or have an operculum on the occlusal surface of the tooth. Soft tissue impacted third molars should also be reevaluated carefully. Please contact us about such teeth.

Areas of trauma

- **I**dentify and eliminate all sources of oral trauma and irritation such as ill-fitting dentures, orthodontic bands, and other appliances.

Thank you for helping to prepare your patient for head and neck cancer therapy. If you have any questions, please do not hesitate to contact your patient's oncologist or an Oral Medicine specialist at our hospital at bwhoralmedicine@partners.org. Rev. 9/2016

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CANCER CENTER

HEAD AND NECK CANCER THERAPY
DENTAL EVALUATION (P1 of 2)

Please complete EVERY portion of this form

Patient's Name: _____

Patient's Address: _____

Date of Birth (DD/MM/YYYY):_____

Examiner's Name: _____

Examiner's Address: _____

Examiner's Phone No.: ( ) _____

Patient has been part of your practice since _____ (year)

Patient's cancer diagnosis _____

Patient's Past Dental History: Please comment if you circle Y.

Y N Periodontal therapy _____

Y N Endodontic therapy _____

Y N History of pericoronitis _____

Y N Removable prosthesis _____

Date of enclosed radiographs _____

Extra-oral Examination _____

DANA-FARBER/BRIGHAM AND WOMEN'S

CANCER CENTER

HEAD AND NECK CANCER THERAPY
DENTAL EVALUATION (P2 of 2)

Intra-oral Examination:

Y N Symptomatic teeth _____

Y N Soft tissue lesions _____

Y N Caries _____

Y N Fractured or defective restorations _____

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

Y N Percussion sensitivity _____

Y N Areas of gingival bleeding on provocation
_____

Y N Teeth with pockets >4 mm _____

Y N Teeth with mobility Grades 2 or 3 _____

Y N Areas of suppuration/fistulae/sinus tract _____

Y N State of removable prosthesis _____

Y N Third molars present _____

Location of distal gingiva on #17 circle one occlusal 1/3 mid 1/3 cervical 1/3
Location of distal gingiva on #32 circle one occlusal 1/3 mid 1/3 cervical 1/3

If occlusal 1/3, please comment on distal pocketing, symptoms and appearance of gingival tissues in the area_____

Amount of plaque present: None slight moderate heavy
Amount of calculus present: None slight moderate heavy
Your rating of home care: Poor Fair Good Excellent

Periodontal disease classification: ADA I II III IV

Radiographic findings:
Presence of apical lucencies: _____

Other findings (clinical and radiographic):
_____

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HEAD AND NECK CANCER THERAPY
TREATMENT PLAN (P1 of 1)

Dates: Procedures:

_____

_____

_____

_____

_____

_____

Scaling and Prophylaxis (date completed): _____
This must be within the last three months

Thank you.

_____
Signature of examiner

_____
Name of examiner

_____
Examiner Specialty

_____
Date of evaluation

Division of Oral Medicine and Dentistry, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115, (617) 732-6974