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 **bone marrow (Hematopoietic Stem Cell) transplantation.**

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: **BMT, Smith, J 1.1.1955** – this is the name of service (BMT), 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: **BMT, Smith, J 1.1.1955** – this is the name of service (BMT), 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 UNDEROING BONE MARROW (HEMATOPOIETIC STEM CELL) TRANSPLANTATION

Your patient is presenting to you for a dental evaluation in preparation for bone marrow (hematopoietic stem cell) transplantation (HSCT), a potentially life-saving procedure used to treat cancer and certain non-cancerous blood disorders. Good oral health may minimize complications during and after transplantation. During admission for transplantation, 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 transplantation and we ask for your assistance in achieving this.

Please give your patient priority for an appointment to expedite dental care. You probably have only one to two weeks in which to complete your evaluation and treatment.

Please read the following instructions carefully. For questions regarding dental issues or the dental evaluation form, please call Brigham and Women's Oral Medicine and Dentistry at (617)-732-6974. For medically related questions, please ask the patient for their oncologist's contact information.

1) Perform a complete dental evaluation, full mouth periodontal charting and **obtain a complete full mouth series of radiographs (without complete FMX, we won't be able to review the case and proceed with dental evaluation required prior to admission which may delay the transplant)**. Complete the attached evaluation, including your treatment plan (total of 3 pages).

- 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.

2) If the platelet count is less than 50,000, or if the white cell count is less than 2,000, consult with your patient's oncologist or our oral medicine specialists before commencing treatment. Your patient should be able to tell you what his/her counts are. **However, you should proceed with the radiographs and full evaluation even if counts are low.**

TREATMENT PLANNING

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 transplantation.

The proposed dental treatment may be affected by your patient's specific medical diagnosis and treatment schedule. Some general guidelines for dental preparation prior to transplantation include the following:

Restorative treatment

- Restore all carious teeth.
- Your patient may receive up to 1400 cGy of total body radiation but 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. During your patient's hospital stay, which typically lasts 2-4 weeks, s/he will be using a soft toothbrush and rinsing with chlorhexidine.
- 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 hospital admission.

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

- Identify and eliminate all sources of oral trauma and irritation such as ill-fitting dentures, orthodontic bands, 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 on bisphosphonate therapy (e.g. Zometa), which places the patient at risk for developing jaw osteonecrosis. Please contact us if extractions are in the treatment plan.

If you have any questions, please do not hesitate to contact us.

Rev. 9/2016

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DENTAL EVALUATION FORM (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 _____

(If you use digital films, please Email them to: bwhoralmedicine@partners.org. If you use non-digital films, please make a copy of radiographs for yourself as these will not be returned to you.)

Extra-oral Examination _____

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DENTAL EVALUATION FORM (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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DENTAL 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