Community Dental Services

Dental Management of Patient with Advanced Dementia

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Introduction

Older patients with dementia have poor oral health (1); attributed to a complex range of factors including a reduced ability to self care, discontinuation of routine care and the inability to identify pain. A decline in cognition can lead to limited cooperation for dental treatment (2). The proportion of edentulous older adults has decreased by 22% since 1978 and there is a need to maintain complex restorative work. CQC reported that when people enter care homes, they stop receiving routine check ups and their oral health is rarely assessed (3). This leads to a subsequent worsening of oral health and malnutrition.

Case History

An 87-year-old female patient attended with her daughter who had sought a referral to the community dental services. The patient's daughter was concerned about her weight loss, which she felt was due to oral pain as her carers had reported that she was not eating well.

She suffered with non -insulin - dependent diabetes, kidney failure and advanced dementia. She was taking a combination of medication to stabilize her mood including antipsychotics, a benzodiazepine, and opiates.

The patient had moved in February from London to a care home in Bedford. She did not speak English and her daughter translated for her in Italian. Her daughter had taken her to a general dentist in August however the patient became aggressive when being examined.

The patient was seen in the community dental services in September, she did not recall any oral pain at this appointment. She allowed a brief examination and radiographs to be taken.

Examination

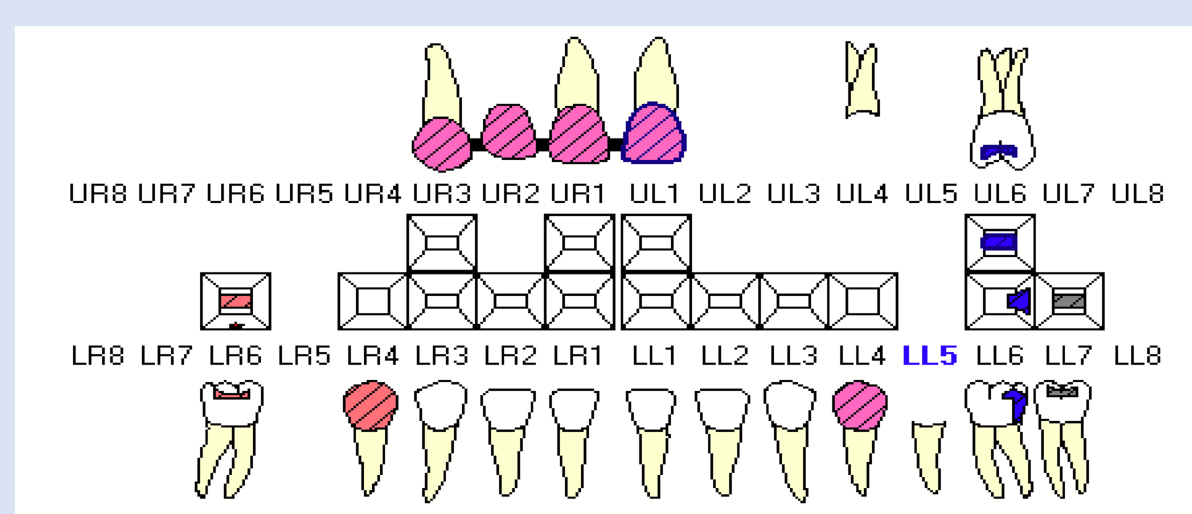

Fig 1. Dental Chart

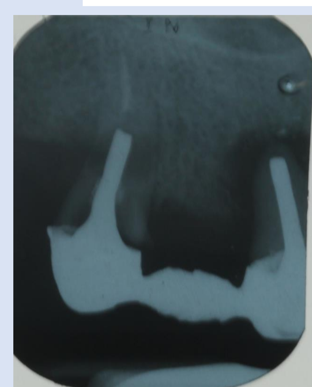

Fig 2. PA UR3 – UR1

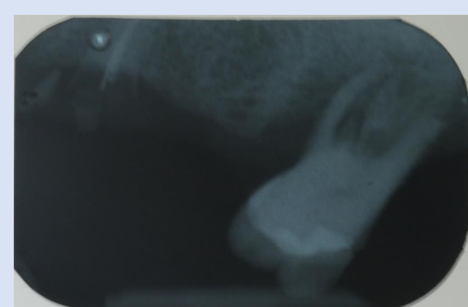

Fig 3. PA UL6

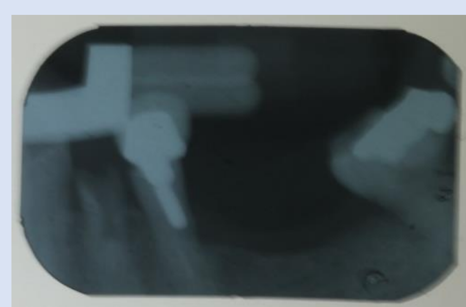

Fig 4. PA LL2 – LL6

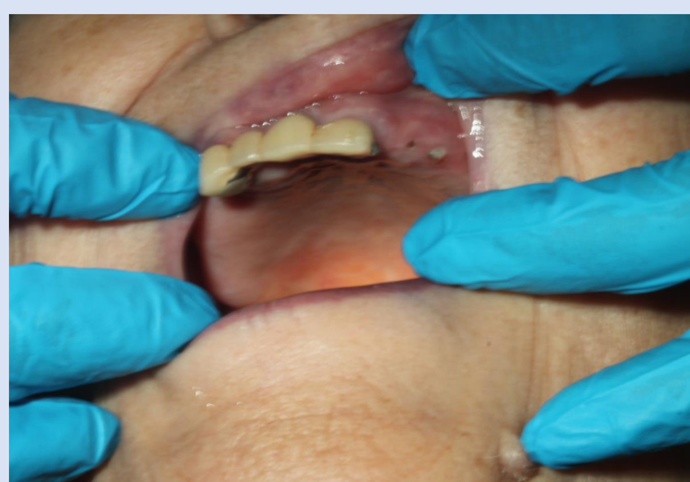

Fig 5. UR3 – UL1 view

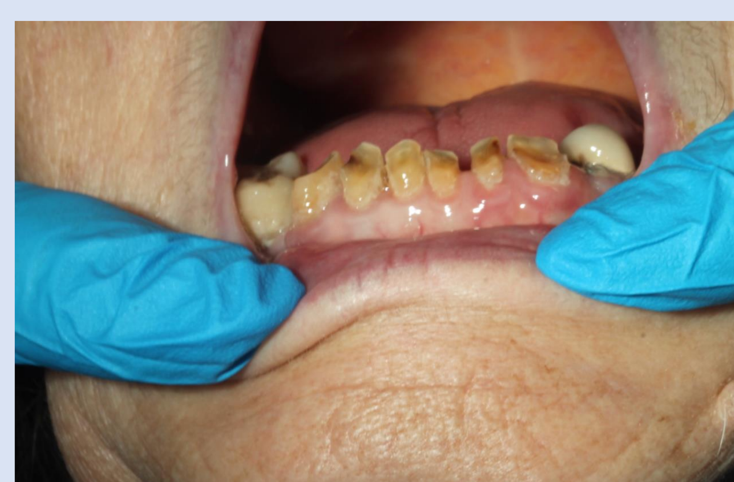

Fig 6. LR4 – LL4 view

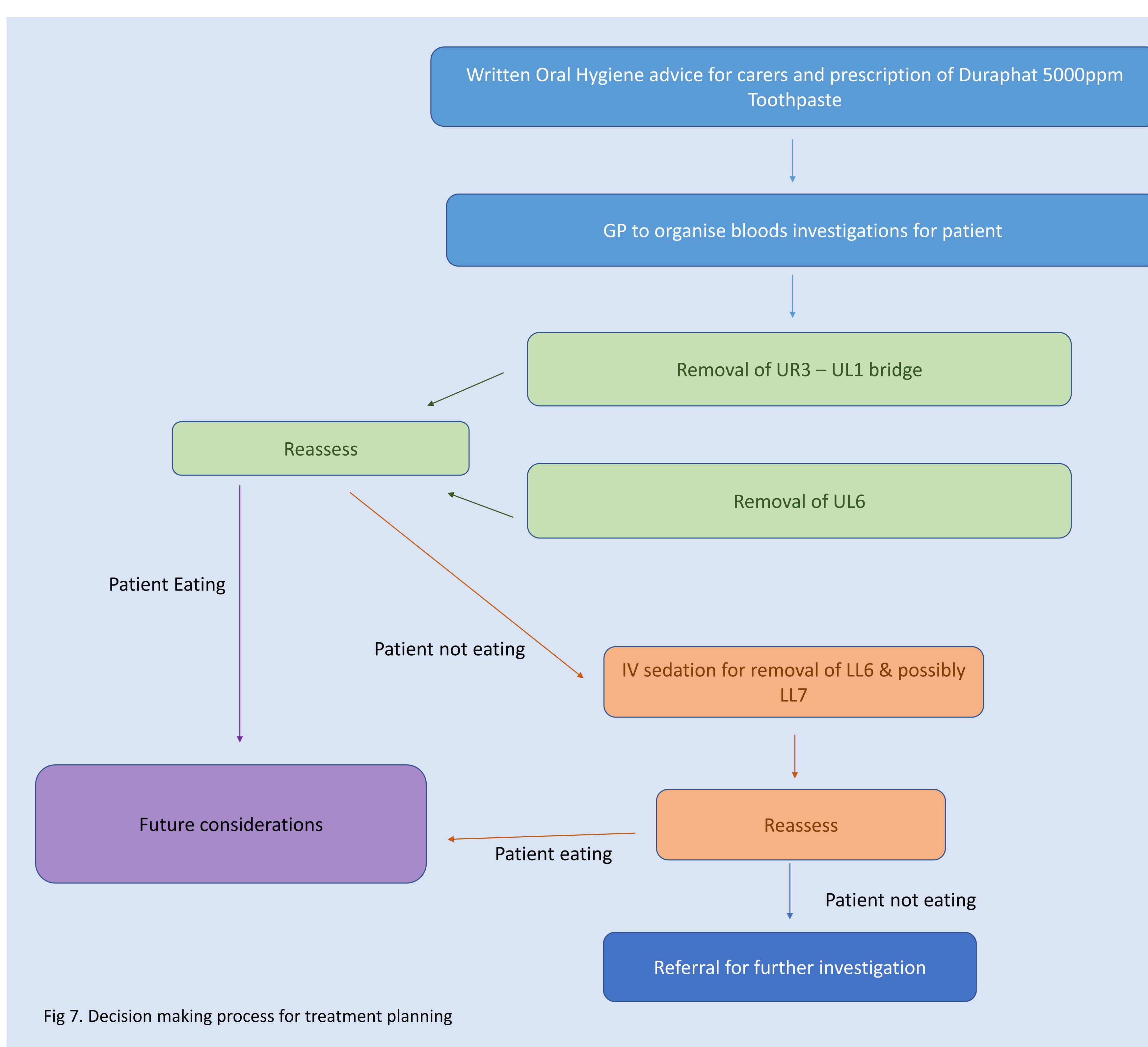

Fig 7. Decision making process for treatment planning

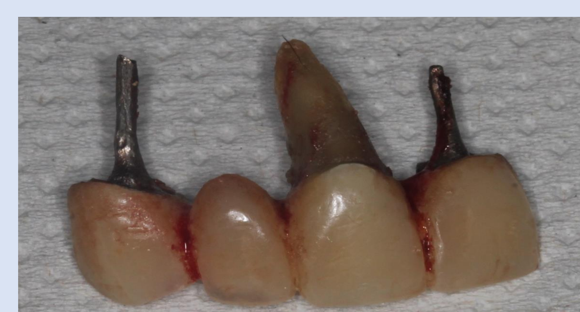

Fig 8. UR3 – UL1 bridge

Diagnosis

1. Generalised periodontitis stage 3 Grade B
2. UR3 - mid third root fracture
3. UR1 – Chronic Apical Periodontitis
4. Ur3- UL1 – Failure of bridge
5. UL4 – Retained Root
6. LL6 distal caries
7. LL5 retained root
8. LR3 – LL3 – Basic Erosive Wear Examination score 2

Treatment Plan

The patient did not have a Health and Welfare power of attorney. A best interest decision was made involving the patient's daughter, a specialist in special care dentistry, a dental officer, the care home manager and her GP. It was decided that the likely source of pain was the mobile upper bridge, and the UL6. A dynamic treatment plan was formulated (Fig 7). The following was considered when formulating the plan:

- Patient was unable to recall a pain history
- Medical History
- Patient cooperation and available sedation techniques
- Advice from family and health and social care practitioners

The GP advised against intravenous sedation in primary care . The patient's daughter felt that it was not in her mother's best interests to attend the hospital due to the pandemic and her cognitive decline. It was decided that treatment would be attempted under LA, using oral sedation.

Using a combination of local anaesthesia and behavioural techniques the anterior bridge and UL6 was removed. A week later the care home manager reported that the patient was eating better.

Future Considerations

This patient will benefit from daily assessment of her oral condition by her carers, and access to specialist dental services through domiciliary care. Regular preventative advice to her carers and the prescription of high fluoride adjuncts will be beneficial. Patient's with advanced dementia find it difficult to wear dentures (4), therefore future prosthetic management may not be successful.

Conclusion

This case highlights the need to manage failing complex restorations in the early stages of dementia. This will help to prevent the challenges faced in regard to consent, cooperation and anaesthetic technique. The Enhanced Health in Care Homes Model aims to develop integrated care for patients as soon as they enter residential care (5). This will require training in oral health for entire social care team and better sharing of patient information through improving electronic records (6).

References

1) Delwel S, Binnekade TT, Perez RS, Hertogh CM, Scherder EJ, Lobbezoo F. *Oral health and orofacial pain in older people with dementia: a systematic review with focus on dental hard tissues.* Clin Oral Investigation, 21(1):17-32. 2017
2) Geddis-Regan, A., Walton, G. *A guide to treatment planning in complex older adults. Br Dent J* 225, 395–399. 2018
3) Care Quality Commission. *Smiling Matters Oral health care in care homes.* 2019
4) Edwards J, Ford L, Boyle C. *Dementia and Dentistry.* Dental Update, 42: 464–472. 2015
5) NHS England & NHS Improvement. The framework for Enhanced Health in Care homes Version 2. 2020
6) NHS England & NHS Improvement. *Dental Record Keeping Standards: a consensus approach.* 2019

Acknowledgments to CDS – CIC *www.communitydentalservices.co.uk*