COVID implications for a Medically Compromised Older Adult with a Deteriorating Dentition

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Introduction

The UK has an ageing population, and the 85+ age group is the fastest growing [1]. With regards to dentistry, an older patient can face barriers when accessing care. With ageing there is an increase in: comorbidities, polypharmacy, physical access restrictions and cognitive impairment. In addition, the dentition is often heavily restored, periodontal disease increases and treatment options are compromised. COVID19 has amplified the barriers to accessing dental care. A significant proportion of the clinically vulnerable, who were advised to shield were in the 75+ age group [2].

Case Report

Dental History
Referred from GDP into Oral Surgery Department for extraction asymptomatic lower retained roots.
Decision made to withhold interventive treatment due to COVID guidelines
- Re-referred June 2021

Social History
Lives at home,
Daughter is full time Carer and lives with the patient
Wheelchair user
Daughter assist's with transfer
Domiciliary Community nursing

Male
90

Medical History
Atrial Fibrillation
Angina
Ischaemic Heart Disease
Hypertension
Lung Fibrosis
Previous Pulmonary Embolism
Previous Cerebrovascular accident
Bladder Cancer
Liver Cirrhosis
Gout
Chronic Kidney Disease-Stage 3
Osteoarthritis
Pressure Ulcers and wound care needed
History of recent infections- Chest, skin, UTI
Medications: uses oxygen, dual anti-coagulant therapy, steroids, GTN

Examination

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PCO:
- Pain in all lower retained roots
- Inability to eat without being in discomfort
- Inability to wear dentures
- History of recent weight loss

EOE:
- Frail, considerable bruising to body
- Hearing aids

Hard Tissues:
- Retained Roots LR4-LL3, all TTP and carious

Soft Tissues:
- Edentulous upper ridge
- Ulcer lower labial surface of lip associated with sharp LR1
- Nil abscess/ sinus present

Denture assessment:
- Upper full acrylic denture, retention, stability, aesthetics- optimal
- Lower overdenture- stability-poor, extension-optimal

Diagnosis

1. Grossly carious lower retained roots LR4-LL3
2. Ill fitting lower denture
3. Traumatic ulcer lower labial surface

Treatment Plan

1. Staged extraction of the lower retained roots
2. Referral back to the GDP for denture management, e.g.: soft reline/ remake

Appointments

28/9/21- Remote telephone consultation.
INR checked 1.6

29/9/21- First appointment
Daughter transferred patient onto dental chair
Supplemental oxygen used at 4L
Saturation monitoring throughout- saturations above 96%
Pillow used to aid patient position
Lignocaine infiltrations, elevation of LR4321
Local haemostasis measures- Surgicel and Sutures placed

12/10/21- Remote telephone consultation,
Confirmation ulcer has resolved

Pending- Second appointment for extraction LL123

Challenges

Dental Concerns
Denture wearing ability decreases with age, modifications to his existing denture would be preferable, over construction of a new denture. As his mucosa and musculature may struggle to adapt, and difficulties eating may persist.

Medical Concerns
- Stressful environment may precipitate Cardiovascular event
- Concomitant anticoagulation therapy increase risk of bleeding
- Risk of infection increased due to complex medical history and poor wound healing

Covid Concerns
Patients within the Shielding/ Vulnerable group, had to be specifically assessed on risk vs benefit of being seen and receiving treatment. Treatment provision was restricted to emergency access only, and an AAA response was adopted for all non urgent patients. This was to prevent the risk of contraction of COVID19 contraction, which could potentially have been fatal for this patient group.

In this case:

Referral July 2020 → Remote triage-no intervention deemed necessary → Re-Referred June 2021 → Patient seen Oct 2021

Considerations

It is worthwhile to reflect upon the decision to postpone intervention following the initial referral. Despite the risk of exposure to COVID-19 in the dental environment, attendance for treatment could have prevented future pain, reduced function and weight loss. Further delays were experienced as a result of backlogs in the clinic. The patient required specialist input to deliver this care. Consideration should be given to the following:

1. Was the patient referred to the most appropriate service? Should the patient have been referred and seen within the Special Care Dental Service, he meets the entry requirements, he has a complex medical history and he would benefit being seen in a secondary care setting.
2. Why was the patient not flagged as a re-referral? The GDP should act as an advocate and when Re-Referring, take ownership for the referral pathway, ensure the referral is highlighted as a second referral and follow up. There should be additional communications if the patient is in pain and the referral needs expediting. Within the Oral Surgery Referral system, it is not set up to link historic referrals.

Discussion

During the COVID19 Pandemic there was a level of uncertainty regarding resumption of dental services and access for patients. The message was clear for Shielded and Vulnerable patients to only leave the house when necessary.
With regards to this case, the initial referral was triaged correctly and the optimal treatment plan was chosen, ultimately to keep this patient safe. Dental pain is unpredictable and this adds additional challenges to the treatment planning process. The complex risk/benefit analysis that a clinician is required to balance when proposing surgical intervention has been further complicated by the risk of contracting the potentially fatal COVID-19. Unfortunately these teeth did cause problems, and accessing the appropriate services was a challenge. In this case there was a delay. Which could have been reduced with better communication between the Referrer and the Oral Surgery Department. Alternatively a referral into Special Care Dental Service, may have allowed the patient to have been more promptly.

Conclusion

This case highlights the importance of strong relationships between primary and secondary care settings, and a shared care approach when managing complex patients. Evermore so during the COVID19 pandemic. Overall responsibility for the patient lies with the GDP, but carers/ family involved should also feel empowered to seek care especially when the patient is in pain.

References

1 Ageuk.org.uk. 2021. [online] Available at: <https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/later_life_uk_factsheet.pdf> [Accessed 10 November 2021].
2. Ons.gov.uk. 2021. *Coronavirus and shielding of clinically extremely vulnerable people in England - Office for National Statistics*. [online] Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronavirusandshieldingofclinicallyextremelyvulnerablepeopleinengland/28mayto3june2020> [Accessed 10 November 2021].