

# Dental recall

Recall interval between routine dental  
examinations

**Clinical Guideline 19**

October 2004

Developed by the National Collaborating Centre for  
Acute Care

## **Clinical Guideline 19**

### **Dental recall: recall interval between routine dental examinations**

**Issue date:** October 2004

This document, which contains the Institute's full guidance on Dental recall: recall interval between routine dental examination, is available from the NICE website ([www.nice.org.uk/CG019NICEguideline](http://www.nice.org.uk/CG019NICEguideline)).

An abridged version of this guidance (a 'quick reference guide') is also available from the NICE website ([www.nice.org.uk/CG019quickrefguide](http://www.nice.org.uk/CG019quickrefguide)). Printed copies of the quick reference guide can be obtained from the NHS Response Line: telephone 0870 1555 455 and quote reference number N0734.

Information for the Public is available as a poster or a factsheet from the NICE website or from the NHS Response Line (for the poster quote reference number N0735 for a version in English and N0736 for a version in English and Welsh; for the factsheet quote reference number N0737 for a version in English and N0738 for a version in English and Welsh).

#### **This guidance is written in the following context:**

This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Health professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

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The quick reference guide for this guideline has been distributed to the following:

- Primary care trust (PCT) chief executives
- Local health board (LHB) chief executives
- NHS trust chief executives in England and Wales
- Strategic health authority chief executives in England and Wales
- Medical and nursing directors in England and Wales
- Clinical governance leads in England and Wales
- Audit leads in England and Wales
- NHS trust, PCT and LHB libraries in England and Wales
- Patient advice and liaison co-ordinators in England
- General Dental Surgeons in England and Wales
- Chief pharmacists, heads of drug purchasing, heads of drug information, GP prescribing advisors and purchase advisors in England and Wales
- NHS Director Wales
- Chief Executive of the NHS in England
- Chief Medical, Nursing and Pharmaceutical Officers in England and Wales
- Medical Director and Head of NHS Quality - Welsh Assembly Government
- Community health councils in Wales
- Commission for Healthcare Audit and Inspection
- NHS Clinical Governance Support Team
- Patient advocacy groups
- Representative bodies for health services, professional organisations and statutory bodies and the Royal Colleges

## Contents

<b>Introduction</b> .....	<b>5</b>
<b>1 Guidance</b> .....	<b>7</b>
<b>2 Notes on the scope of the guidance</b> .....	<b>11</b>
<b>3 Implementation in the NHS</b> .....	<b>11</b>
<b>4 Research recommendations</b> .....	<b>12</b>
<b>5 Other versions of this guideline</b> .....	<b>13</b>
<b>6 Related NICE guidance</b> .....	<b>14</b>
<b>7 Review date</b> .....	<b>15</b>
<b>Appendix A: Grading scheme</b> .....	<b>16</b>
<b>Appendix B: The Guideline Development Group</b> .....	<b>18</b>
<b>Appendix C: The Guideline Review Panel</b> .....	<b>21</b>
<b>Appendix D: NHS England clinical care pathways: overview of oral health assessment and oral health review</b> .....	<b>22</b>
<b>Appendix E: Implementing the guideline recommendations</b> .....	<b>23</b>

## Introduction

Six-monthly dental check-ups have been customary in the General Dental Service (GDS) in the United Kingdom since the inception of the NHS. In recent years there has been significant debate over the timing of recall intervals for dental check-ups, and this has coincided with a move towards making NHS dental services in England and Wales more oriented to prevention and more clinically effective in meeting patients' needs.

The Department of Health's strategy document *NHS Dentistry: Options for Change* (2002) and subsequent legislation are bringing about changes in the organisation of dental services and the way in which oral health is assessed. Under the new arrangements, a comprehensive oral health assessment (OHA) will be conducted when a patient first visits a dental practice and will involve taking full histories, carrying out thorough dental and head and neck examinations and providing initial preventive advice. The dentist and patient will discuss the findings and agree a personalised care plan and a 'destination' for this journey of care. The dental team and patient will then work through this first personal care plan (see Appendix D).

After an agreed interval, the patient will return for an oral health review (OHR), during which the histories and examination will be updated and any changes in risk factors noted. The dental team will also assess the effectiveness of the treatment and preventive advice provided previously, and will give more advice as necessary. The patient and dentist will discuss the findings of the review and agree the next, refined, personalised care plan and a specific 'destination' for this new journey of care (see Appendix D).

The purpose of this guideline is to help clinicians assign recall intervals between oral health reviews that are appropriate to the needs of individual patients. The recommendations apply to patients of all ages (both dentate and edentulous) receiving primary care from NHS dental staff in England and Wales. The guideline takes into account the potential of the patient and the dental team to improve or maintain the patient's quality of life and to reduce morbidity associated with oral and dental disease.

The recommendations take account of the impact of dental checks on: patients' well-being, general health and preventive habits; caries incidence and avoiding restorations; periodontal health and avoiding tooth loss; and avoiding pain and anxiety.

This guideline does not cover:

- recall intervals for scale and polish treatments
- the prescription and timing of dental radiographs
- intervals between examinations that are not routine dental recalls; that is, intervals between examinations relating to ongoing courses of treatment
- emergency dental interventions or intervals between episodes of specialist care.

The following guidance is based on the best available evidence. There is evidence relating to risk factors for oral disease and on the effectiveness of dental health education and oral health promotion, and this was used to inform the guideline recommendations. However, the research evidence on many aspects of dental recall intervals was limited, and recommendations were based on the clinical experience of the Guideline Development Group and advice received during the consultation process.

The grading scheme used for the recommendations (A, B, C, D or good practice point [GPP]) is described in Appendix A; a summary of the evidence on which the guidance is based is provided in the full guideline (see Section 5).

# 1 Guidance

Section 1.1 of this guidance contains the clinical recommendations. Tools to support clinicians in implementing these recommendations can be found in Appendix E.

## 1.1 *Clinical recommendations*

- 1.1.1 The recommended interval between oral health reviews should be determined specifically for each patient and tailored to meet his or her needs, on the basis of an assessment of disease levels and risk of or from dental disease. **D**
- 1.1.2 This assessment should integrate the evidence presented in this guideline with the clinical judgement and expertise of the dental team, and should be discussed with the patient. **GPP**
- 1.1.3 During an oral health review, the dental team (led by the dentist) should ensure that comprehensive histories are taken, examinations are conducted and initial preventive advice is given. This will allow the dental team and the patient (and/or his or her parent, guardian or carer) to discuss, where appropriate:
- the effects of oral hygiene, diet, fluoride use, tobacco and alcohol on oral health **B**
  - the risk factors (see the checklist in Appendix E) that may influence the patient's oral health, and their implications for deciding the appropriate recall interval **D**
  - the outcome of previous care episodes and the suitability of previously recommended intervals **GPP**
  - the patient's ability or desire to visit the dentist at the recommended interval **GPP**
  - the financial costs to the patient of having the oral health review and any subsequent treatments. **GPP**

1.1.4 The interval before the next oral health review should be chosen, either at the end of an oral health review if no further treatment is indicated, or on completion of a specific treatment journey. **GPP**

1.1.5 The recommended shortest and longest intervals between oral health reviews are as follows.

- The shortest interval between oral health reviews for all patients should be 3 months. **GPP**

*A recall interval of less than 3 months is not normally needed for a routine dental recall. A patient may need to be seen more frequently for specific reasons such as disease management, ongoing courses of treatment, emergency dental interventions, or episodes of specialist care, which are outside the scope of an oral health review.*

- The longest interval between oral health reviews for patients younger than 18 years should be 12 months. **GPP**

*There is evidence that the rate of progression of dental caries can be more rapid in children and adolescents than in older people, and it seems to be faster in primary teeth than in permanent teeth (see full guideline). Periodic developmental assessment of the dentition is also required in children.*

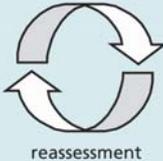
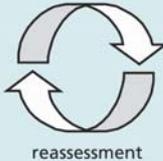
*Recall intervals of no longer than 12 months give the opportunity for delivering and reinforcing preventive advice and for raising awareness of the importance of good oral health. This is particularly important in young children, to lay the foundations for life-long dental health.*

- The longest interval between oral health reviews for patients aged 18 years and older should be 24 months. **GPP**

*Recall intervals for patients **who have repeatedly demonstrated that they can maintain oral health and who are not considered to be at risk of or from oral disease** may be extended over time*

*up to an interval of 24 months. Intervals of longer than 24 months are undesirable because they could diminish the professional relationship between dentist and patient, and people's lifestyles may change.*

- 1.1.6 For practical reasons, the patient should be assigned a recall interval of 3, 6, 9 or 12 months if he or she is younger than 18 years old, or 3, 6, 9, 12, 15, 18, 21 or 24 months if he or she is aged 18 years or older. **GPP**
- 1.1.7 The dentist should discuss the recommended recall interval with the patient and record this interval, and the patient's agreement or disagreement with it, in the current record-keeping system. **GPP**
- 1.1.8 The recall interval should be reviewed again at the next oral health review, to learn from the patient's responses to the oral care provided and the health outcomes achieved. This feedback and the findings of the oral health review should be used to adjust the next recall interval chosen. Patients should be informed that their recommended recall interval may vary over time. **GPP**

Overview of how the interval between oral health reviews is set			
		Children and young people <i>If the patient is younger than 18 years</i>	Adults <i>If the patient is 18 years or older</i>
Step 1	<ul style="list-style-type: none"> <li>Consider the patient's age; this sets the range of recall intervals</li> </ul>	3 months ↔ 12 months	3 months ↔ 24 months
Step 2	<ul style="list-style-type: none"> <li>Consider modifying factors (see checklist on page 24) in the light of patient's medical, social and dental histories and findings of the clinical examination</li> </ul>	3 months ↔ 12 months	3 months ↔ 24 months
Step 3	<ul style="list-style-type: none"> <li>Integrate all diagnostic and prognostic information, considering advice from other members of the dental team where appropriate</li> <li>Use clinical judgement to recommend interval to the next oral health review</li> </ul>	3 months ↔ 12 months	3 months ↔ 24 months
Step 4	<ul style="list-style-type: none"> <li>Discuss recommended interval with the patient</li> <li>Record agreed interval or any reason for disagreement</li> </ul>		
Step 5	<ul style="list-style-type: none"> <li>At next oral health review, consider whether the interval was appropriate</li> <li>Adjust the interval depending on the patient's ability to maintain oral health between reviews</li> </ul>		

*The interval may be maintained at the same level if it is achieving its aims. For someone with low disease activity, it may be possible to gradually extend the interval towards the 24-month maximum period – once the patient and the dental team are confident that this is satisfactory. Patients whose disease activity continues unabated may need a shorter interval and may need more intensive preventive care and closer supervision.*

*Patients should be encouraged to seek advice from a dentist before their next scheduled review if there are any significant changes in their risk factors. They also need to understand that (as is the case with the current 6-month recall regimen) there is no guarantee that new disease will not develop between recall visits.*

## **2 Notes on the scope of the guidance**

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development of this guideline, after a period of consultation; it is available from [www.nice.org.uk/Docref.asp?d=84419](http://www.nice.org.uk/Docref.asp?d=84419)

## **3 Implementation in the NHS**

### ***3.1 In general***

Local health communities should review their existing practice for dental recall against this guideline. The review should consider the resources required to implement the recommendations set out in Section 1, the people and processes involved, and the timeline over which full implementation is envisaged. It is in the interests of patients that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly.

This guidance contains tools and suggestions to facilitate implementation and review (see Appendix E). These are designed to help NHS dental practices and their patients get used to what will be for many a new way of planning and receiving routine NHS dental care. A quick reference guide for the dental team, and a poster and leaflet for the public are also available (see Section 5).

### **NHS clinical care pathways**

NHS clinical care pathways are being developed to further the aims outlined in the Department of Health's strategy document *NHS Dentistry: Options for Change* (2002). The first clinical care pathway for NHS dentistry is being developed by the Dental Health Services Research Unit at the University of Dundee and deals with the initial oral health assessment and subsequent oral health reviews (see diagram in Appendix D). It is being tested by NHS Options for Change field sites, which include dental practices, primary care trusts and strategic health authorities who volunteered to test the modernisation

proposals outlined in *Options for Change*. The pathway accommodates the NICE recommendations on recall intervals and this should help a seamless move into modernised, preventive NHS dental care.

### **3.2 Audit**

Patient records should show that appropriate recall intervals have been identified, based on the assessment of risk in discussion with the patient. The following criteria can be used to audit adherence to the guideline recommendations.

3.2.1 At the end of each oral health review there is a record for each patient of an assessment of disease and disease risk.

3.2.2 At the end of each oral health review, or at completion of treatment, there is a record for each patient of the recall interval recommended by the dentist for the next oral health review.

3.2.3 The interval agreed each time, for each patient is:

- 3, 6, 9 or 12 months for patients younger than 18 years, or
- 3, 6, 9, 12, 15, 18, 21 or 24 months for patients aged 18 years or older.

3.2.4 Where there is disagreement between the dentist and the patient over the recall interval, the reason for this is recorded.

Further information on local and national audit is available in the full guideline.

## **4 Research recommendations**

While developing this guideline, the research evidence in a number of areas was found either to be inconclusive or not to exist. Research in the following areas would help in updating this guideline and implementing it in general dental practice.

- Dental attendance patterns should be examined for changes after the publication of the guideline.

- After publication of the guideline, information will be needed on whether patients visit the dentist at the agreed interval, and their reasons for this.
- Research is needed on the long-term clinical and cost effectiveness of one-to-one oral health advice and whether this may depend on:
  - the frequency with which it is delivered
  - the physical or oral health of the patient
  - other characteristics of the patient (for example, age, sex, social class, occupation)
  - the medium used to deliver the advice
  - who delivers the advice.
- Research is needed to examine the effects of varying dental recall intervals on oral health, and on which aspects of the oral health review influence oral health.
- Research is needed to examine the impact of oral health (relating to gingivitis, caries, periodontal disease and mucosal disease) on quality of life.
- Research is needed to examine the effects on periodontal health of routine scale and polish treatment (in conjunction with oral hygiene instruction) in different populations. Specifically, research is needed to examine the clinical effectiveness and cost effectiveness of providing this intervention at different time intervals.

Research designs will need to accommodate the mix of arrangements (NHS, private and mixed configurations) under which dental primary care is provided.

## **5 Other versions of this guideline**

The National Institute for Clinical Excellence commissioned the development of this guidance from the National Collaborating Centre for Acute Care. The Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The members of the Guideline Development Group are listed in Appendix B. Information about the independent Guideline Review Panel is given in Appendix C.

The booklet *The guideline development process – an overview for stakeholders, the public and the NHS* has more information about the Institute's guideline development process. It is available from the Institute's website and copies can also be ordered by telephoning 0870 1555 455 (quote reference N0472).

### ***Full guideline***

The full guideline, 'Dental recall: recall interval between routine dental examinations', is published by the National Collaborating Centre for Acute Care; it is available on its website ([www.rcseng.ac.uk/about\\_the\\_college/role\\_of\\_the\\_college\\_nccac\\_html](http://www.rcseng.ac.uk/about_the_college/role_of_the_college_nccac_html)); printed copies can be ordered at a cost. The guideline is also available on the NICE website ([www.nice.org.uk/CG019fullguideline](http://www.nice.org.uk/CG019fullguideline)) and on the website of the National electronic Library for Health ([www.nelh.nhs.uk](http://www.nelh.nhs.uk)).

### ***Information for the public***

This guideline is different from other guidelines in that the whole population is affected. A poster and factsheet explaining the guidance are available from the NICE website ([www.nice.org.uk/CG019publicinfo](http://www.nice.org.uk/CG019publicinfo)). Printed copies are available from the NHS Response Line (0870 1555 455). For the poster, quote reference number N0735 for an English version and N0736 for a Welsh version). For the factsheet, quote N0737 for the English version and N0738 for the Welsh version. The factsheet can also be downloaded from the website and copied for patients. This is a good starting point for explaining why a patient's recommended recall interval may have changed.

### ***Quick reference guide***

A quick reference guide for healthcare professionals is also available from the NICE website ([www.nice.org.uk/CG019quickrefguide](http://www.nice.org.uk/CG019quickrefguide)) or from the NHS Response Line (0870 1555 455; quote reference number N0734).

## **6 Related NICE guidance**

There is no related NICE guidance.

## **7 Review date**

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

## Appendix A: Grading scheme

The recommendation grading scheme and hierarchy of evidence used in this guideline are adapted from the Scottish Intercollegiate Guidelines Network (*SIGN 50: A guideline developers' handbook*), and summarised in the tables below.

Recommendation grade	Evidence
A	<ul style="list-style-type: none"> <li>• At least one meta-analysis, systematic review, or randomised controlled trial (RCT) rated as 1<sup>++</sup> (see table on page 17), and directly applicable to the target population, <b>or</b></li> <li>• A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1<sup>+</sup>, directly applicable to the target population, and demonstrating overall consistency of results</li> </ul>
B	<ul style="list-style-type: none"> <li>• A body of evidence including studies rated as 2<sup>++</sup>, directly applicable to the target population, and demonstrating overall consistency of results, <b>or</b></li> <li>• Extrapolated evidence from studies rated as 1<sup>++</sup> or 1<sup>+</sup></li> </ul>
C	<ul style="list-style-type: none"> <li>• A body of evidence including studies rated as 2<sup>+</sup>, directly applicable to the target population and demonstrating overall consistency of results, <b>or</b></li> <li>• Extrapolated evidence from studies rated as 2<sup>++</sup></li> </ul>
D	<ul style="list-style-type: none"> <li>• Evidence level 3 or 4, <b>or</b></li> <li>• Extrapolated evidence from studies rated as 2<sup>+</sup>, <b>or</b></li> <li>• Formal consensus</li> </ul>
D (GPP)	<ul style="list-style-type: none"> <li>• A good practice point (GPP) is a recommendation for best practice based on the clinical experience of the Guideline Development Group</li> </ul>

Level of evidence	Type of evidence
1 <sup>++</sup>	<ul style="list-style-type: none"> <li>• High-quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias</li> </ul>
1 <sup>+</sup>	<ul style="list-style-type: none"> <li>• Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias</li> </ul>
1 <sup>-</sup>	<ul style="list-style-type: none"> <li>• Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias</li> </ul>
2 <sup>++</sup>	<ul style="list-style-type: none"> <li>• High-quality systematic reviews of case-control or cohort studies</li> <li>• High-quality case-control or cohort studies with a very low risk of confounding, bias or chance, and a high probability that the relationship is causal</li> </ul>
2 <sup>+</sup>	<ul style="list-style-type: none"> <li>• Well-conducted case-control or cohort studies with a low risk of confounding, bias or chance, and a moderate probability that the relationship is causal</li> </ul>
2 <sup>-</sup>	<ul style="list-style-type: none"> <li>• Case-control or cohort studies with a high risk of confounding, bias or chance, and a significant risk that the relationship is not causal</li> </ul>
3	<ul style="list-style-type: none"> <li>• Non-analytic studies (for example, case reports, case series)</li> </ul>
4	<ul style="list-style-type: none"> <li>• Expert opinion, formal consensus</li> </ul>

## **Appendix B: The Guideline Development Group**

### **Professor Nigel Pitts (Chair)**

Professor of Dental Health and Director of the Dental Health Services Research Unit, University of Dundee

### **Dr Paul Batchelor**

Consultant in Dental Public Health, Eastman Dental Hospital, University College London; Research Director of the Centre for Dental Services Studies, University of York; British Association for the Study of Community Dentistry

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### **Dr Clare Davenport**

Clinical Research Fellow, West Midlands Health Technology Assessment Collaboration, University of Birmingham

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### **Mrs Eleanor Grey**

Patient Representative; formerly Chair of the Lay Advisory Group, Faculty of General Dental Practitioners (UK)

**Dr Kathryn Harley**

Consultant in Paediatric Dentistry and Honorary Senior Lecturer, Edinburgh Dental Institute

**Ms Sara Hawksworth**

Patient Representative; National Development Officer, Age Concern England

**Professor Mike Lewis**

Professor of Oral Medicine, Wales College of Medicine, University of Cardiff

**Mr Peter Lowndes**

General Dental Practitioner, Birmingham; Faculty of General Dental Practitioners (UK)

**Mr Mike Mulcahy**

General Dental Practitioner, Worthing, West Sussex; Faculty of General Dental Practitioners (UK)

**Mr Derek Richards**

Director, Centre for Evidence-Based Dentistry, Oxford

**Dr Richard Seppings**

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Senior Lecturer in Periodontology and Director, International Centre for  
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**Ms Louise Thomas**

Research Associate, NCC-AC

**Mr David Wonderling**

Health Economist, NCC-AC

## **Appendix C: The Guideline Review Panel**

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring its quality. The Panel includes experts on guideline methodology, health professionals and people with experience of the issues affecting patients and carers. The members of the Guideline Review Panel were as follows:

### **Mr Peter Robb (Chair)**

Consultant ENT Surgeon, Epsom and St Helier University Hospitals and the Royal Surrey County NHS Trusts

### **Mrs Joyce Struthers**

Patient Representative, Bedford

### **Dr Peter Duncan (Deputy Chair)**

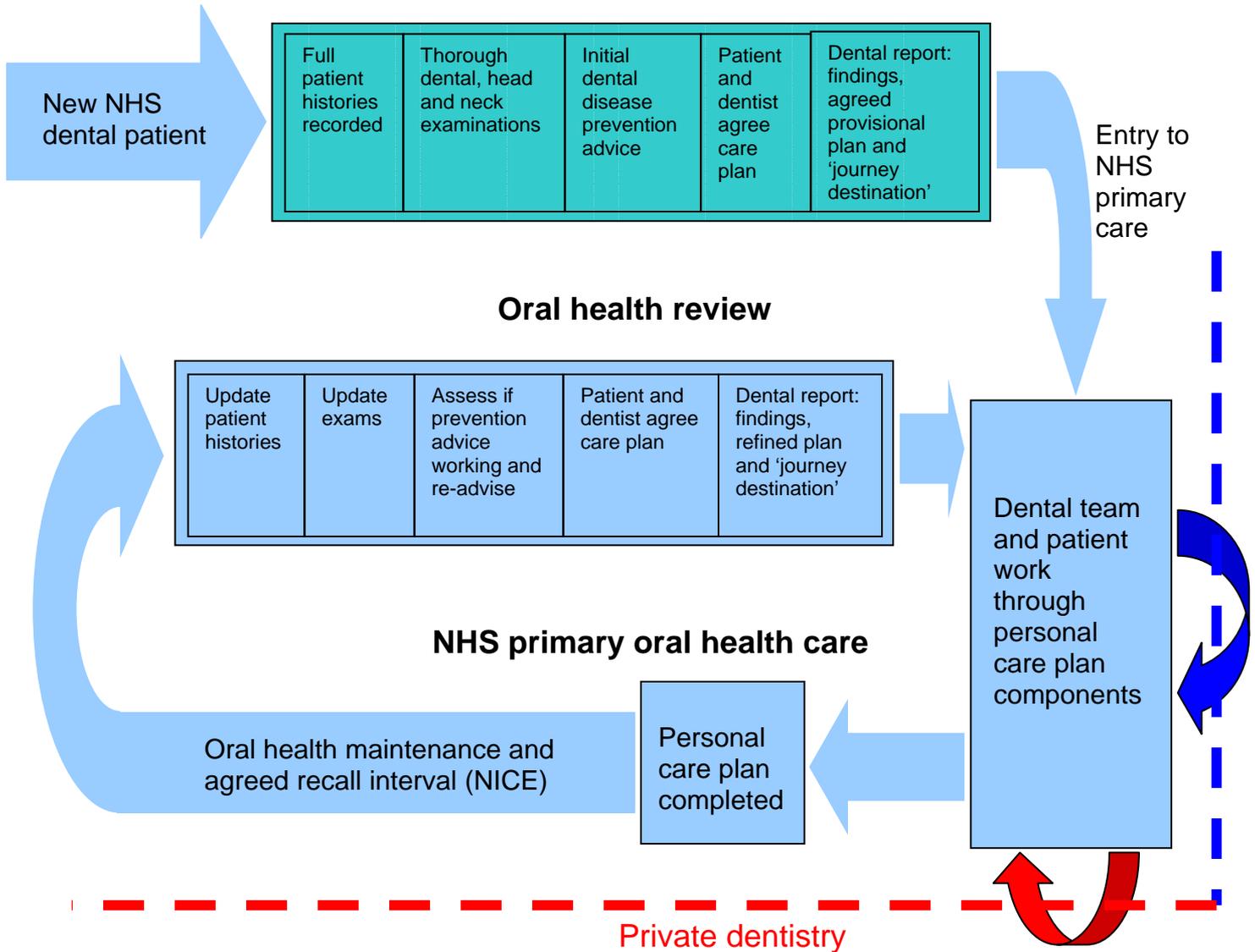
Consultant in Anaesthetics and Intensive Care Medicine, Royal Preston Hospital, Preston

### **Mrs Anne Williams**

Deputy Director of Clinical Governance, Kettering General Hospital NHS Trust, Northamptonshire

# Appendix D: NHS England clinical care pathways: overview of oral health assessment and oral health review

## Oral health assessment



## **Appendix E: Implementing the guideline recommendations**

### ***E1. How to identify the risk factors***

#### **E1.1 Introduction**

When selecting an appropriate recall interval, dentists must integrate their own clinical expertise with the best available clinically relevant scientific evidence relating to the patient's oral and general health. This guideline aims to assist dentists in this decision-making process by:

- advocating that dentists should carry out a risk assessment for each patient
- identifying specific factors that should be taken into account when assigning a recall interval for each patient.

The frequency and type of oral health supervision a patient needs depends on the likelihood of diseases or conditions developing. Assessing the patient's risk factors and protective factors at each oral health review allows the dentist to make specific preventive and treatment recommendations, and to assign a recall interval appropriate for their needs.

The checklist on page 24 lists factors to consider when carrying out a risk assessment. There is insufficient evidence to assign a weight to individual factors, and dentists must use their clinical judgement to weigh the risk and protective factors for each patient.

The checklist is presented as a preliminary guide to assist the dental team in assigning recall intervals. Dentists may use it as it is or modify it to develop their own electronic records or patient questionnaire. It would be appropriate for patients to receive a copy of their checklist on request.

## E1.2 Checklist of modifying factors

Checklist of modifying factors							
Name:		Date of birth:					
Oral health review date:							
<b>Medical history</b>		Yes	No	Yes	No	Yes	No
Conditions where dental disease could put the patient's general health at increased risk (such as cardiovascular disease, bleeding disorders, immunosuppression)		<input type="checkbox"/>					
Conditions that increase a patient's risk of developing dental disease (such as diabetes, xerostomia)		<input type="checkbox"/>					
Conditions that may complicate dental treatment or the patient's ability to maintain their oral health (such as special needs, anxious/nervous/phobic conditions)		<input type="checkbox"/>					
<b>Social history</b>							
High caries in mother and siblings		<input type="checkbox"/>					
Tobacco use		<input type="checkbox"/>					
Excessive alcohol use		<input type="checkbox"/>					
Family history of chronic or aggressive (early onset/juvenile) periodontitis		<input type="checkbox"/>					
<b>Dietary habits</b>							
High and/or frequent sugar intake		<input type="checkbox"/>					
High and/or frequent dietary acid intake		<input type="checkbox"/>					
<b>Exposure to fluoride</b>							
Use of fluoride toothpaste		<input type="checkbox"/>					
Other sources of fluoride (for example, the patient lives in a water-fluoridated area)		<input type="checkbox"/>					
<b>Clinical evidence and dental history</b>							
<b>Recent and previous caries experience</b>							
New lesions since last check-up		<input type="checkbox"/>					
Anterior caries or restorations		<input type="checkbox"/>					
Premature extractions because of caries		<input type="checkbox"/>					
Past root caries or large number of exposed roots		<input type="checkbox"/>					
Heavily restored dentition		<input type="checkbox"/>					
<b>Recent and previous periodontal disease experience</b>							
Previous history of periodontal disease		<input type="checkbox"/>					
Evidence of gingivitis		<input type="checkbox"/>					
Presence of periodontal pockets (BPE code 3 or 4) and/or bleeding on probing		<input type="checkbox"/>					
Presence of furcation involvements or advanced attachment loss (BPE code *)		<input type="checkbox"/>					
<b>Mucosal lesions</b>							
Mucosal lesion present		<input type="checkbox"/>					
<b>Plaque</b>							
Poor level of oral hygiene		<input type="checkbox"/>					
Plaque-retaining factors (such as orthodontic appliances)		<input type="checkbox"/>					
<b>Saliva</b>							
Low saliva flow rate		<input type="checkbox"/>					
<b>Erosion and tooth surface loss</b>							
Clinical evidence of tooth wear		<input type="checkbox"/>					
Recommended recall interval for next oral health review:		months		months		months	
Does patient agree with recommended interval? If 'No', record reason for disagreement in notes		Yes	No	Yes	No	Yes	No
BPE code * is used when attachment loss is $\geq 7$ mm and/or furcation involvements are present							

## The rationale for including modifying factors in the checklist

Factor	Reason for inclusion
<b>Medical history</b>	
<p><b>Conditions where dental disease could put the patient's general health at risk, such as:</b></p> <ul style="list-style-type: none"> <li>• Cardiovascular disease carrying an increased risk of infective endocarditis</li> <li>• Haematological conditions, bleeding disorders or anti-coagulant therapy</li> <li>• Immunosuppression</li> </ul>	<p>More frequent recalls may be needed and emphasis should be placed on primary prevention (the prevention of oral disease before it occurs) and secondary prevention (limiting the progression and effect of oral diseases at as early a stage as possible after onset), to minimise the need for operative intervention.</p>
<p><b>Conditions that increase the patient's risk of developing dental disease, such as:</b></p> <ul style="list-style-type: none"> <li>• Diabetes</li> <li>• Xerostomia or 'dry mouth', for example resulting from cancer treatments, conditions such as Sjögren's syndrome, or drug treatment</li> <li>• Conditions requiring the use of long-term medications containing glucose, sucrose or fructose</li> <li>• Phenytoin therapy for epilepsy</li> </ul>	<p>People with diabetes (type 1 or type 2) are at increased risk of destructive periodontal disease, and may need a more frequent recall, particularly if plaque control is inadequate.</p> <p>People with inadequate salivary function and reduced salivary flow rate are at increased risk of dental caries and may require more frequent oral health reviews.</p> <p>Extended recall intervals are not appropriate because of the potential for rapid progression of caries.</p> <p>Gingival overgrowth may occur as a side effect of phenytoin therapy, and poor oral hygiene is the most important risk factor for this. More frequent recalls for oral hygiene advice may help. But improved plaque control may have little effect in reducing the fibrous component of gingival overgrowth, although it may help the inflammatory component.</p>

<ul style="list-style-type: none"> <li>Acid reflux into the mouth, such as in gastro-oesophageal reflux and eating disorders, especially bulimia</li> </ul>	<p>This increases the risk of tooth surface wear. More frequent recall may be helpful, to monitor the teeth and for preventive advice (for example, avoiding brushing the teeth immediately after vomiting or acid reflux).</p>
<p><b>Conditions that may complicate dental treatment or the patient's ability to maintain their oral health, such as:</b></p> <ul style="list-style-type: none"> <li>Special needs, such as learning disabilities</li> <li>Cleft lip/palate, severe malocclusion</li> <li>Anxious, nervous or phobic conditions</li> </ul>	<p>Emphasis should be placed on primary and secondary prevention, to minimise the need for operative intervention which may require a general anaesthetic in a hospital setting. More frequent recalls may help nervous patients acclimatise to dental procedures via non-invasive preventive interventions.</p>
<p><b>Social history</b></p>	
High caries in mothers and siblings	This is an indicator of increased caries risk for an individual child.
Tobacco use	This is the most significant modifiable risk factor for periodontal disease, and is a risk factor for oral cancer.
Excessive alcohol use	This is a risk factor for oral cancer, and has a synergistic effect with tobacco use. A high level of vigilance is needed where these factors are associated with clinical evidence of potentially malignant lesions. Oral cancer can occur in young people with little or no exposure to tobacco or alcohol, so every oral health review should include a thorough examination of the mucosa.
Family history of chronic or aggressive (early onset/juvenile) periodontitis	Periodontitis, particularly aggressive periodontitis, can occur in families. Clinicians should consider the impact of a positive family history, especially if the stability of the patient's periodontal status is not yet demonstrated.
<p><b>Dietary habits</b></p>	
High and/or frequent sugar intake	High sugar intake increases caries risk, as may long-term regular use of medications containing glucose, fructose or sucrose (see also section on medical history on page 25). The Faculty of Dental Surgery's National Clinical Guidelines (1997) suggest that more than three sugary intakes daily indicates increased caries risk.
High and/or frequent dietary acid intake	Many soft drinks are acidic and contain considerable amounts of simple sugars, so they have both erosive and cariogenic potential (see also section on erosion and tooth surface loss on page 28).

<b>Exposure to fluoride</b>	
Use of fluoride toothpaste	Regular brushing with a fluoride-containing toothpaste reduces caries risk.
Other sources of fluoride, such as living in a water-fluoridated area	Caries risk assessments should take into account the fluoride status of local water supplies, and the fact that a person may not always have lived in a fluoridated area.
<b>Recent and previous caries experience</b>	
New lesions since last check-up; anterior caries or restorations; premature extractions because of caries; past root caries or large number of exposed roots; heavily restored dentition	The most consistent predictor of caries risk is past caries experience.
<b>Recent and previous periodontal disease experience</b>	
Previous history of periodontal disease	This indicates increased susceptibility and risk of future disease.
Evidence of gingivitis	This is a risk factor for periodontitis, although only a minority of people with gingivitis will progress to periodontitis. A continuous absence of gingival bleeding is a reliable predictor of periodontal health.
Presence of periodontal pockets (Basic Periodontal Examination [BPE] code 3 or 4) and/or bleeding on probing  Presence of furcation involvements or advanced attachment loss (BPE code *)	Sites with existing/advanced periodontitis are at greater risk of future breakdown than healthy sites.
<b>Mucosal lesions</b>	
Any mucosal lesion, particularly precursor lesions and conditions, such as leukoplakia, erythroplakia, oral lichen planus and oral submucous fibrosis	Oral cancer can arise from clinically normal mucosa, or from precursor lesions. Erythroplakia has a high potential for malignant transformation. Leukoplakia lesions on the floor of the mouth, lateral tongue and lower lip are most likely to show dysplastic or malignant change. Clinicians should have a high index of suspicion for all intra-oral areas that appear unusual.
<b>Plaque</b>	
Poor level of oral hygiene	Dental plaque is a key factor in the development of dental caries and periodontal diseases.
Plaque-retaining factors	Plaque-retaining factors include appliances (orthodontic appliances, partial dentures), existing restorations, crowded teeth, deep fissures.

Saliva	
Low saliva flow rate	See section on medical history on page 25.
<b>Erosion and tooth surface loss</b>	
Clinical evidence of tooth wear	Tooth wear is caused by a combination of abrasion, attrition and erosion. Management may include appropriate oral hygiene instruction, provision of occlusal protection, dietary assessment and counselling, and assessment of reflux. Regular follow-up is needed to determine if the dentition is stable or deteriorating.

### **E1.3 Using the checklist as part of a risk assessment**

This checklist forms part of a three-stage risk assessment process.

#### ***a) Identifying risk and protective factors***

This involves using the checklist to identify aspects of the patient's medical and social history and behavioural habits that may impact on their oral health. The usefulness of some of these factors in assessing a patient's risk may be limited by inaccurate self-reporting of dietary habits, oral hygiene practices, smoking and alcohol consumption. Many oral diseases are also multifactorial and it is important to consider the combinations of factors present in a patient rather than individual factors.

#### ***b) Evaluating the impact of these factors on a patient's oral health***

This involves carrying out a thorough oral examination to determine the patient's past and current disease experience. Past caries experience is the most reliable predictor of future caries experience. However, changes in behavioural and other modifying factors can reduce its predictive power in an individual patient. This emphasises the importance of carrying out a risk assessment to detect any such changes and to evaluate their impact every time a patient attends for an oral health review.

#### ***c) Predicting the patient's future risk of disease***

This involves the dentist integrating all the collected information and using his or her clinical judgement to predict what the patient's future disease experience is likely to be. The dentist can then choose an appropriate recall interval that is tailored to meet the patient's individual needs. The ability to assign an appropriate recall interval will improve over time as the dentist builds up an accurate record of the patient's disease experience and determines the rate at which disease is progressing. Such a record may not exist for new or recent patients to a practice and the dentist may be uncertain about what recall interval to assign. A conservative recall interval can be assigned initially and progressively altered over time on the basis of the risk assessment performed at each oral health review. For example, a dentist will not know if a 'white spot lesion' in a new patient has recently appeared or has

been present without progressing for years. An appropriate course of action is to apply topical fluoride, give preventive advice and assign a short recall interval initially to monitor the lesion. If the lesion fails to progress over time, the recall interval can be increased.

The same principles will apply for new patients with a medical history that may increase their risk of or from dental disease, or for patients who have recently developed such conditions. A conservative recall interval should be assigned initially and extended over time in accordance with the clinical evidence and other data obtained at each oral health review.

It is advisable to inform patients (and/or their parents, guardians or carers) that the same interval may not be appropriate at every stage in their life – it may vary if their risk and protective factors alter. Both clinician and patient should attempt to reduce the patient's risk factors and enhance protective factors, and alter the recall interval accordingly.

With experience, clinicians should be able to carry out a risk assessment quickly, easily and intuitively as part of an oral health review.

## Factors to consider when deciding a patient's recall interval



## E1.4 Examples of clinical scenarios involving recall interval selection

The clinical scenarios on the following pages illustrate the process of assigning a recall interval. They are not intended to capture every clinical situation that a dentist may encounter.

### Patient A

**Age:** 4 years.

**Attendance record:** Attending your practice for the first time (for an oral health assessment).

**Medical history:** None of note.

**Social history:** Two older siblings aged 7 and 10 years, who have been patients of yours for the past 2 years. Both have no decayed, missing or filled teeth and have good oral hygiene.

**Dietary habits:** Apparently healthy; no risk factors for caries.

**Use of fluoride:** Brushes twice daily with a fluoride-containing toothpaste.

**Clinical evidence/dental history:** No caries or fillings and no other factors that may increase caries risk.

**Plaque:** Good oral hygiene; minimal plaque deposits.

**Saliva:** Normal.

**Other:** None.

**Recall interval recommended for next oral health review:** 6 months.

**Rationale:** The history and examination reveal no medical or social history of note and the patient has no cavities and good oral hygiene and dietary practices. However, this is a new patient with no established dental history, so you assign a conservative recall interval of 6 months initially.

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### Patient B

**Age:** 14 years.

**Attendance record:** Has attended your practice for regular reviews since the age of 5 years.

**Medical history:** None of note.

**Social history:** One younger sibling aged 11 years who is caries free. The patient's mother is also caries free.

**Dietary habits:** Apparently healthy; no risk factors for caries.

**Use of fluoride:** Brushes twice daily with a fluoride-containing toothpaste.

**Clinical evidence/dental history:** No previous history of dental caries and no other risk factors for caries; healthy gingiva.

**Plaque:** Good oral hygiene; minimal plaque deposits.

**Saliva:** Normal.

**Other:** None.

**Recall interval recommended for next oral health review:** 12 months.

**Rationale:** This patient is a regular attender with known past history. There is no current evidence or past history of dental disease, the medical history is clear and there are no additional risk factors. Hence the patient is considered to be at low risk and a review interval of 12 months seems reasonable.

**SUBSEQUENT HISTORY:** The patient develops new caries in two molars at the age of 16 years. She has developed a habit of frequent consumption of sugar-containing foods and drinks between meals and her oral hygiene has deteriorated. The recall interval is reduced to 6 months. After intensive prevention, the lapses in dietary practices and oral hygiene are reversed and no new caries are subsequently seen.

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### Patient C

**Age:** 11.5 years.

**Attendance record:** Attending your practice for the first time (for an oral health assessment).

**Medical history:** None of note.

**Social history:** Two older siblings aged 13 and 15 years, who have been patients of yours for the past 2 years. Both siblings have had decay in the primary and permanent dentition. The patient's mother also has a high DMFT (decayed, missing and filled teeth) score.

**Dietary habits:** Consumes carbonated soft drinks at least three times a day.

**Use of fluoride:** Irregular brushing; lives in an area with sub-optimal levels of fluoride in the water.

**Clinical evidence/dental history:** Three restorations in primary teeth and there is one carious lesion in a first permanent molar requiring restoration; gingival inflammation in all areas.

**Plaque:** Oral hygiene is poor.

**Saliva:** Normal.

**Other:** None.

**Treatment plan:** Preventive advice and restoration of first permanent molar.

**Recall interval recommended for next oral health review:** 3 months.

**Rationale:** The patient has a large number of risk factors and this is his first visit to the practice so a short recall interval is appropriate.

**SUBSEQUENT HISTORY:** After pro-active prevention, the patient reduces consumption of carbonated drinks between meals, improves oral hygiene and uses a fluoride-containing toothpaste regularly twice daily. Over subsequent visits no new caries is seen and the recall interval is initially extended to 6 months.

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## Patient D

**Age:** 35 years.

**Attendance record:** Has attended your practice regularly for 6 years.

**Medical history:** None of note.

**Social history:** Non-smoker and drinks alcohol occasionally at the weekends.

**Dietary habits:** Healthy diet with plenty of fresh fruit and vegetables and rarely consumes sugar-containing foods and drinks.

**Use of fluoride:** Brushes twice a day with a fluoride-containing toothpaste.

**Clinical evidence and dental history:** No missing teeth, 5 occlusal amalgam fillings in permanent molar teeth. These were placed 15 years ago and have not needed replacement, all are still in excellent condition. Bitewing radiographs taken 12 months ago revealed no interproximal lesions. On examination, the patient's periodontal health is excellent (Basic Periodontal Examination [BPE] code 0 all sextants).

**Plaque:** Brushes twice a day and uses dental floss once a day. Has not needed oral hygiene instruction or debridement for 3 years.

**Saliva:** Normal.

**Other:** None.

**Recall interval recommended for next oral health review:** 24 months.

**Rationale:** Over a 6-year period at your dental practice, this patient has not required any restorative intervention. The patient has not had any new carious lesions over a 15-year period and has excellent oral hygiene and dietary habits. The patient's periodontal health is excellent and dental status appears stable, suggesting that a recall interval of 24 months is appropriate.

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## Patient E

**Age:** 20 years.

**Attendance record:** Has attended your practice every 12 months for 5 years.

**Medical history:** None of note.

**Social history:** Non-smoker, consumes alcohol occasionally at the weekends.

**Dietary habits:** Healthy diet with low frequency of intake of sugar-containing foods and drinks.

**Use of fluoride:** Brushes twice a day with a fluoride-containing toothpaste.

**Clinical evidence and dental history:** Two occlusal amalgam fillings present in permanent molar teeth. The fillings were placed 6 years ago and are still in excellent condition. Bitewing radiographs taken 12 months ago revealed no signs of interproximal lesions.

**Plaque:** Brushes twice a day and uses dental floss once a day. Excellent oral hygiene and has not needed oral hygiene instruction or any debridement for 3 years.

**Saliva:** Normal.

**Other:** None.

**Recall interval recommended for next oral health review:** 24 months.

**Rationale:** Over a 5-year period at your dental practice, this patient has not required any restorative intervention. The patient's past caries experience is minimal and he has not had any new carious lesions over a 6-year period. He has good oral hygiene and dietary practices, and his periodontal health is also excellent. His dental status is judged to be stable, suggesting that a recall interval of 24 months is appropriate.

**SUBSEQUENT HISTORY:** The patient returns for an oral health review after 24 months. He has been living away from home for the past 18 months, having just started college. His dietary habits have changed, and he is now consuming a lot of carbonated soft drinks and 'junk food'. Oral hygiene has deteriorated – he is brushing irregularly, does not always use fluoride-containing toothpaste, and flosses 'occasionally'. One new carious lesion (requiring restorative intervention) has developed on the occlusal surface of one molar tooth. Bitewing radiographs reveal one interproximal lesion. Two 'white spot' lesions are present on the buccal surfaces of two molar teeth. There is evidence of gingivitis in all sextants with calculus deposits on the lingual surfaces of the lower anterior teeth (BPE codes 1–2). The patient undergoes a course of treatment involving restoration of the carious lesions, oral hygiene instruction, debridement of all plaque and calculus, dietary advice, and the application of topical fluoride to white spot lesions. Recall interval for next oral health review is shortened to 6 months. He is advised that a longer interval may be recommended in the future if subsequent oral health reviews reflect improvements in dietary habits and oral hygiene.

---

## Patient F

**Age:** 45 years.

**Attendance record:** Has attended your practice every 6 months for 3 years.

**Medical history:** None of note.

**Social history:** Non-smoker and a 'moderate' drinker.

**Dietary habits:** Healthy, balanced diet and, following dietary advice given at previous oral health reviews, confines intake of sugar-containing foods and drinks to mealtimes with no between meal snacking.

**Use of fluoride:** Brushes twice a day with a fluoride-containing toothpaste.

**Clinical evidence and dental history:** The patient required considerable restorative work when first attending 3 years ago and oral hygiene at that time was poor. However, the patient has not experienced any new carious lesions since then, nor has any restorative work needed further attention. The patient's oral hygiene has improved significantly. Bitewing radiographs reveal no approximal lesions and good alveolar bone support. The BPE demonstrates gingival bleeding in two sextants but no pocketing or attachment loss (BPE code 1).

**Plaque:** Brushes twice a day and uses dental floss occasionally. Oral hygiene is satisfactory, although there are plaque deposits around the cervical margins of the upper and lower molar teeth.

**Saliva:** Normal.

**Other:** None.

**Treatment plan:** Further oral hygiene advice, followed by debridement of plaque deposits.

**Recall interval recommended for next oral health review:** 12 months.

**Rationale:** Over a 3-year period at your dental practice, this patient has not required any further restorative intervention after the initial course of treatment. The patient has shown good compliance with dietary and oral hygiene advice given, although the patient should be helped to improve oral hygiene around the molar teeth. Although the patient's dental status appears relatively stable at this time, you do not think it is advisable to increase the interval beyond 12 months because you feel it may be necessary to review oral hygiene.

---

## Patient G

**Age:** 55 years.

**Attendance record:** Has attended your practice for 1 year.

**Medical history:** None of note.

**Social history:** Smokes 35 cigarettes a day and drinks alcohol daily. Has tried to give up smoking in the past but without success.

**Dietary habits:** Apparently healthy diet.

**Use of fluoride:** Uses a fluoride-containing toothpaste twice daily.  
**Clinical evidence/dental history:** Wears an upper partial denture. The remaining dentition is sound. No obvious mucosal disease.  
**Plaque:** Good oral hygiene.  
**Saliva:** Normal.  
**Other:** None.

**Recall interval recommended for next oral health review:** 6 months.

**Rationale:** The patient has two recognised factors associated with oral cancer and would therefore benefit from regular review of the oral mucosa.

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## Patient H

**Age:** 65 years.  
**Attendance record:** Has attended your practice for 5 years.  
**Medical history:** Asthmatic and uses a corticosteroid inhaler.  
**Social history:** Non-smoker and has occasional alcohol.  
**Dietary habits:** Apparently healthy diet.  
**Use of fluoride:** Brushes twice a day with a fluoride-containing toothpaste.  
**Clinical evidence/dental history:** The patient is edentulous and has full dentures that are 3 years old. There is a white patch on the right lateral margin of the tongue that was assessed by biopsy in a specialist unit 5 years before and reported as a non-dysplastic leukoplakia. The patient was discharged back to the practice for ongoing care.  
**Plaque:** Maintains good denture hygiene.  
**Saliva:** Normal.  
**Other:** The patient has suffered from recurrent candidal infections associated with inhaled corticosteroid therapy.

**Recall interval recommended for next oral health review:** 6 months.

**Rationale:** The patient has a recognised potentially malignant condition at a high-risk site in the mouth. Review of the mucosa at 6-monthly intervals would increase the likelihood of early detection of any malignant change.

---

## Patient I

**Age:** 56 years.  
**Attendance record:** First attended your practice 6 months ago and has been compliant in completing a course of non-surgical periodontal therapy.  
**Medical history:** Taking low-dose aspirin because of family history of coronary heart disease.  
**Social history:** Non-smoker; moderate alcohol intake of approximately 14 units per week.  
**Dietary habits:** Mix of rushed meals during the week and a reasonably balanced diet at weekends.  
**Use of fluoride:** Brushes twice a day with a fluoride-containing tooth-whitening toothpaste.  
**Clinical evidence and dental history:** The teeth are heavily restored with a mix of large amalgam restorations and a few crowns. Although there used to be some moderately deep pockets (BPE code 3) in most sextants, only four 5 mm pockets remain, without bleeding on probing, following non-surgical periodontal therapy. Gingival health is otherwise excellent.  
**Plaque:** Brushes twice a day and uses interdental brushes two to three times per week. The plaque score is reasonably low (25%) and is mainly limited to lingual or palatal molar surfaces.  
**Saliva:** Normal.  
**Other:** None.

**Treatment plan:** The patient receives advice in home-care plaque control and enters supportive periodontal maintenance on a 3-monthly recall.

**Recall interval recommended for next oral health review:** 3 months.

**Rationale:** The response to periodontal therapy is good, although plaque control is not adequate. Because you have no measure of periodontal stability, the patient's periodontal status should be re-examined in 3 months.

---

## Patient J

**Age:** 23 years

**Attendance record:** Has attended your practice regularly from a young age.

**Medical history:** None of note.

**Social history:** Non-smoker; a moderate drinker.

**Dietary habits:** Healthy diet and rarely consumes confectionary.

**Use of fluoride:** Brushes three times a day with a fluoride-containing toothpaste.

**Clinical evidence and dental history:** The patient has never required restorative intervention and her periodontal health is excellent (BPE code 0 all sextants).

**Plaque:** Excellent oral hygiene, brushes three times a day and uses dental floss once a day.

**Saliva:** Normal.

**Other:** None.

**Recall interval recommended for next oral health review:** 18 months.

**Rationale:** Given the patient's long established dental history of no restorations and excellent oral hygiene, a recall interval of 24 months might be appropriate. However, recognising that at the patient's age lifestyles can change suddenly and dramatically, you decide to be cautious and recall in 18 months.

---

## Patient K

**Age:** 21 years.

**Attendance record:** Has attended your practice regularly for 6 years.

**Medical history:** None of note and, apart from the contraceptive pill, is taking no medication.

**Social history:** Non-smoker; a moderate drinker.

**Dietary habits:** Consumes one can of carbonated soft drink per day and one bar of chocolate a day.

**Use of fluoride:** Brushes twice a day with a fluoride-containing toothpaste.

**Clinical evidence and dental history:** No decayed, missing or filled teeth and bitewing radiographs reveal no approximal lesions and good alveolar bone support. The BPE demonstrates gingival bleeding, but no pocketing (BPE code 1) in 5 sextants with calculus present around the lower anterior teeth (BPE code 2).

**Plaque:** Brushes twice a day but does not use dental floss. Oral hygiene is unsatisfactory.

**Saliva:** Normal.

**Other:** None.

**Treatment plan:** The patient receives oral hygiene advice and professional debridement of plaque and calculus.

**Recall interval recommended for next oral health review:** 12 months. Clinician recommends review of oral hygiene with debridement if needed in 6 months.

**Rationale:** Although the patient has some risk factors for dental caries, she has not required restorative intervention and you consider a recall interval of 12 months to be appropriate for the next oral health review. In view of the patient's oral hygiene and periodontal status you recommend a review of oral hygiene with debridement if needed in 6 months.

---

## Patient L

**Age:** 67 years.

**Attendance record:** The patient had full upper and lower dentures fitted by you 2 years ago and subsequently attended twice for easing of the lower denture.

**Medical history:** None of note.

**Social history:** Non-smoker and non-drinker.

**Dietary habits:** Healthy diet (lots of fresh fruit and vegetables).

**Use of fluoride:** Not applicable.

**Clinical evidence and dental history:** Healthy oral mucosa with no evidence of any mucosal lesions. Both upper and lower dentures fit and function well.

**Plaque:** Dentures are free of plaque deposits and the patient rinses them immediately after meals and soaks them in a cleansing solution overnight.

**Saliva:** Normal.

**Other:** None.

**Recall interval recommended for next oral health review:** 24 months.

**Rationale:** This edentulous patient has been fitted with satisfactory dentures and subsequent follow-up has been uneventful. The patient's healthy oral mucosa and established denture-cleansing regimen influence your decision to recall in 24 months. The patient is advised to reattend if there are any problems with the dentures or any change in the oral mucosa.

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## Patient M

**Age:** 69 years.

**Attendance record:** Has attended your practice regularly for 5 years.

**Medical history:** Taking a diuretic and a beta-blocker for blood pressure.

**Social history:** Heavy smoker; you suspect he may be a heavy drinker.

**Dietary habits:** No information available.

**Use of fluoride:** Brushes twice a day with a fluoride-containing toothpaste.

**Clinical evidence and dental history:** White patches present that have been biopsied by a specialist and found to be non-malignant keratotic lesions associated with his tobacco habit. No new carious lesions in the past 5 years. A number of areas with moderate pockets of 4–6 mm (BPE code 3) and/or some sextants with furcation involvements or attachment loss of 7 mm or more.

**Plaque:** Poor oral hygiene; does not use interproximal aids such as interdental brushes or floss.

**Saliva:** Normal.

**Other:** None.

**Treatment plan:** Arrangements are made for the patient to have periodontal care with the hygienist.

**Recall interval recommended for next oral health review:** 6 months.

**Rationale:** The patient has risk factors for oral cancer (mucosal lesions, heavy tobacco use and alcohol consumption). The 'white patches' were biopsied and found to be non-malignant and the patient was referred back to you for continuing care and review. However, it is the patient's periodontal status, rather than his risk factors for oral cancer, that is the main determinant of your choice of recall interval. The patient's oral mucosa will be checked as part of the next oral health review in 6 months.

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## Patient N

**Age:** 48 years.

**Attendance record:** Has attended your practice regularly for 7 years.

**Medical history:** Taking HRT; otherwise none of note.

**Social history:** Quit smoking 9 years ago; drinks on average seven units of alcohol per week.

**Dietary habits:** Healthy, balanced diet.

**Use of fluoride:** Brushes twice a day with a fluoride-containing toothpaste.

**Clinical evidence and dental history:** The teeth are heavily restored but restoration margins are accessible and intact. Although there used to be moderately deep pockets on most teeth (BPE code 3), only three 5 mm pockets remain following non-surgical periodontal therapy, which was completed 5 years ago. These have remained unchanged since and the patient has been attending for supportive periodontal maintenance visits every 3 months. Gingival health is otherwise excellent.

**Plaque:** Brushes twice a day with a fluoride-containing toothpaste and uses interdental brushes every day. There are minimal plaque deposits.

**Saliva:** Normal.

**Other:** None.

**Treatment plan:** The patient should continue on 3-monthly supportive periodontal maintenance visits.

**Recall interval recommended for next oral health review:** 12 months.

**Rationale:** The previous history of periodontitis highlights the need for continuing supportive therapy every 3 months. In view of the stability of the disease at present, the next oral health review should be in 12 months time.

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## Patient O

**Age:** 18 years.

**Attendance record:** Attending your practice for the first time and has attended another practice irregularly over the past 10 years.

**Medical history:** Has Down's syndrome. No other medical history of note.

**Social history:** Lives at home with his parents.

**Clinical evidence and dental history:** Microdontia with short, small clinical crowns and roots. Large amalgam restorations are present in six permanent molar teeth. There are no other restorations or caries lesions present. The patient has already lost two first molar teeth. The gingival health is poor with inflammation present at a number of interproximal sites but there is no significant mobility or drifting of any teeth. Periodontal screening reveals a BPE code of 4 with a number of pockets deeper than 3.5 mm and several around the remaining first molar teeth deeper than 5.5 mm. There is widespread bleeding on probing.

**Plaque:** Brushes twice a day but does not use any interproximal cleaning aids.

**Saliva:** Normal.

**Other:** None.

**Treatment plan:** The patient receives advice in home-care plaque control (this advice is also given to the patient's parents, who are asked to supervise the patient's oral hygiene) and a course of non-surgical periodontal therapy. The patient is placed on 3-monthly supportive periodontal maintenance visits.

**Recall interval recommended for next oral health review:** 3 months.

**Rationale:** The patient has multiple risk factors for the development of periodontal disease. The patient's dental status appears unstable, suggesting that a recall interval of 3 months is appropriate to monitor compliance with oral hygiene advice and the overall response to treatment.