

were somewhat comfortable, and 19.1% were extremely comfortable.

### Factors Influencing Refusal

Caregiver characteristics dentists perceived to be associated with fluoride refusal were immunization refusal (41.3%), White race (37.6%), and high household income (33.7%). Parenting style, insurance restrictions and finances, health concerns, and miscellaneous reasons were also mentioned.

### Geographic Influences

When the western US professionals were compared to others regarding fluoride refusal as a big problem, 20.1% of the westerners and 22.5% of the others saw it as big or medium-sized situation. Significantly larger proportions of participants from non-West regions believed fluoride refusal

has escalated, but more of those from the West expressed a degree of discomfort when talking to caregivers who refused fluoride.

## DISCUSSION

Fluoride refusal by caregivers is a significant and growing problem for dental professionals in the United States. In addition, most dentists are uncomfortable addressing caregivers who refuse the use of fluoride.

Chi DL, Basson AA: Surveying dentists' perceptions of caregiver refusal of topical fluoride. *JDF Clin Translational Res* 3:314-320, 2018

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# GERIATRIC DENTAL TREATMENT PLANNING

## Delivering oral care to older adults



### BACKGROUND

As adults today age, more of them today are retaining their natural dentition or parts thereof, with edentulousness becoming less common than in the past. When those with a sufficient number of natural teeth are combined with those who have a functional dentition, consisting of endodontically treated teeth, crowns, bridges, and osseointegrated implants, dental professionals will increasingly be facing complex demands for the dental care of this population. In addition to dental conditions, these patients often have medical or cognitive deficits that can adversely affect their ability to undergo or consent to dental care. Oral diseases remain a concern in these patients, so dentists must be prepared to provide care that fits the patient's specific situation.

### PROBLEMS TO BE CONSIDERED

#### Frailty

Frail individuals experience loss in one or more areas of function caused by a range of variables and resulting in a higher risk for adverse outcomes. Aging is often a time when frailty is seen as difficulty with mobility and accomplishing daily activities. Often diseases common in later life are also present, including osteoporosis, osteoarthritis, and stroke. Thus frailty is often accompanied by actual physical disabilities. In both types of situations, the individual is increasingly dependent on caregivers and has problems accessing surgeries and transferring to dental chairs. As a result, dental facilities need to be equipped with ramps and equipment to facilitate these activities.

#### Multiple Morbidity and Polypharmacy

Multiple morbidity is more common in older adults and can include mental health conditions as well as physical conditions. Most older adults remain independent, but some require significant support and care, making routine dental treatment in a general dental facility problematic.

With multiple morbid conditions, patients often are given multiple medications. This situation becomes more prevalent as patient age increases. These medications not only increase the likelihood of drug interactions but also can compromise oral health, with xerostomia being a common problem. Dental practices must carefully gather information from the health care teams involved and cautiously approach treatment planning for these patients.

#### Dementia, Mental Capacity, and Consent

When cognitive ability is compromised through dementia or other problems related to mental capacity, this can affect oral health care delivery (Figure 2). Dementia progression can occur at unpredictable rates. As a result, there may be benefits to discussing and providing proactive dental disease management, which may prevent the need for later interventions that might need to address more advanced disease. Patients can present difficulties when practitioners attempt to obtain comprehensive clinical and radiographic evaluations; in addition, the quantification of pain can be especially challenging. When the patient has advanced dementia, cooperation may be minimal, which can require



**Figure 2.** Radiographic assessment of a 84-year-old with fronto-temporal dementia showing a grossly neglected dentition which deteriorated rapidly after a diagnosis of dementia. (Courtesy of Geddis-Regan A, Walton G: A guide to treatment planning in complex older adults. *Br Dent J* 225:395-399, 2018.)

delivering care with the patient under local or even general anesthesia. Advanced care planning and anticipatory treatment planning may be appropriate for patients whose cognitive impairment is expected to increase.

Issues also arise with respect to consent. Patients with mild or early dementia may be treated best in general dental practices where they've established a long-term care relationship. Cognitive changes and accommodations for treatment are

**Table 1.** Assessment and Treatment Sections of Seattle Care Pathway.

		Level of dependency				
		None	Pre	low	Medium	High
Assessment	Adopt appropriate recall intervals	Identify conditions threatening oral health	Identify cause of increasing dependency (for example, stroke, polypharmacy, dementia)	Participate with other medical services to assess health risks generally	Examine patients' physical cognitive and social context for barriers to emergency palliative and elective oral care	
		Develop strategic oral healthcare plan to include professional and self-care	Increase frequency of recall	Reassess long term viability of oral health-related prevention	Monitor the burden of oral care co the patient and others Increase vigilance for signs of elder abuse	
Treatment	Routine	Consider long-term viability of restorations and prostheses. Plan treatment outcomes for easy maintenance	Identify, repair or replace strategically important teeth guided by the principle of the 'shortened dental arch', with or without implants, to maintain oral function	Repair and maintain strategically important teeth with conservative treatments (fee sample, atraumatic restorative technique (ART) with fluoridated glass-ionomer materials), and design oral prostheses to simplify oral hygiene and prevent infection.	Offer palliative treatment on demand from the patient to control pain and infection and maintain social contacts and activities	
			Plan for ongoing maintenance, including restorative and surgical treatments, to maintain function and prevent or control infection and pain	Use prosthodontic attachments between overdentures and abutment teeth or implants to simplify hygiene and maintenance		

Reproduced from Pretty I et al. The Seattle Care Pathway for securing oral health in older patients, *Gerodontology*, Vol. 31, 2014; with permission from John Wiley and Sons. (Courtesy of Geddis-Regan A, Walton G: A guide to treatment planning in complex older adults. *Br Dent J* 225:395-399, 2018.)

often better managed in these situations. Fluctuating mental capacity can be difficult, but consent is often managed with support or by approaching the individual at the right time or in the right circumstances. With advanced dementia, patients can lose the ability to comprehend treatment options and weigh their choices. In these cases, dental practitioners must be aware of the procedures for determining the capacity to consent for health care decisions. They should also understand the governing principles and applicable statutes that cover these situations.

## RESPONSES

### Preventive Care

The prevention of oral disease is a priority for the dental care of older patients to keep their dentitions as healthy as possible and to prevent the need for complex treatment later, with its attendant higher risks for the patient. Many older people would benefit from high fluoride-content toothpastes, regular recall intervals, and the application of fluoride varnish as a regular part of their care. For those in residential care settings, preventive approaches and oral care plans should be developed.

### Safeguarding

Older adults who are frail and suffer dementia can be considered vulnerable individuals who require protection from 'elder abuse' or other neglectful care situations. The dental team should ensure that they are aware of who should be contacted if they suspect such treatment of a patient.

## MANAGEMENT CHOICES

### Establishing Clinical Guidelines

The goal for treating older patients is to safely achieve a pain-free functional dentition, address patients' cosmetic needs, and manage the risk of future disease (Table 1). Treatment options should be developed that fit the dependence level of the patient. Active invasive dental treatment is less appropriate for patients with more advanced dependence issues. Interventions are warranted for pain or infection, but for asymptomatic older persons, risk and benefit should be carefully balanced. For patients in later life, even basic treatment can provide benefits.

### Minimally Invasive Treatment

Patients with greater levels of dependence should be provided minimally invasive symptomatic management on a tooth-by-tooth basis. Some care can be provided in a domiciliary setting, including basic treatments such as managing sharp or broken teeth, shaping dentures, and providing simple restorations. Atraumatic restorative technique is recommended for older patients whose teeth are left in situ to avoid adverse effects related to extractions. A full risk assessment should be done before extractions are undertaken.

### Routine Care

Local anesthesia can be used to facilitate delivery of the full range of dental procedures to older adults. Some patients may be more likely to suffer diseases or have poor oral hygiene, which can be a contraindication to some treatments. It's more important for some patients to retain as many natural teeth as possible, such as those who are taking bisphosphonates. However, when oral conditions and the patient's tolerance of complex procedures are sufficient, the dentist should be able to deliver routine care as for any patient in any age group.

### Complex Care

The provision of complex treatment or complex approaches to treatment must be clearly justified for older patients. Often referral to either hospital or specialist settings will be required in these cases.

Dentists can provide some complex care using local anesthesia, which is both safe and can allow completion of varying degrees of complex treatment. Local anesthetics may not be suitable for patients with extreme anxiety or advanced dementia. Dental practitioners should conduct a comprehensive and detailed history for these patients, which must address the risks of anesthesia in relation to the patient's comorbid conditions.

Intravenous sedation may be appropriate for older patients, although it should be used with caution if it includes benzodiazepines. These agents can provoke sensitivity in older individuals. Many older persons can benefit from inhalation sedation, but it can be insufficient to manage anxiety in patients having more complex treatments. General anesthesia can be appropriate, but the benefits must outweigh the risks associated with age and with systemic effects, which can be long-lasting. Repeated general anesthesia should be avoided if possible, which limits the range of treatments that can be provided.

Treatments should be definitive and predictable. They are typically restricted to scaling, extractions, or simple restorations.

### Clinical Significance

Accomplishing care for older adults can be a challenging undertaking. In addition to all the planning and weighing of benefits and risks, dental care for older adults will require an adequately trained and appropriately available dental workforce. An informed and carefully considered decision not to offer treatment can also be appropriate in some cases. The goal is to provide safe and effective interventions that will ensure the patient enjoys a comfortable oral health status in later life.

Dentists must consider the impact on future function and appearance along with what is in the patient's best interests.

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# HIV

## Managing HIV-positive patients



### BACKGROUND

With our current awareness of bacteria and viruses, protocols have been developed to prevent these agents from being transmitted in health care delivery settings. HIV infection remains associated with many fears concerning its possible transmission risks. Unlike the flu or even the common cold, the risk of spreading HIV virus in the dental setting is minimal as long as appropriate precautions are in place. The legal status afforded patients with HIV, proper protocols and training for health care providers, and confidentiality concerns were addressed.

### LEGAL STATUS OF HIV PATIENTS

Refusing to treat a patient based on his or her HIV status or perceived status can provide grounds for a claim of discrimination. This legal protection is afforded patients by the federal Americans with Disabilities Act as well as state legislation. Patients are not required by law to reveal their HIV status, nor are practitioners prohibited from asking. Sometimes the patient may not be aware of his or her HIV status. Additionally, patients may fear discrimination and choose not to disclose their status on the medical history form. However, dentists should remind patients that some medicines can affect oral health and may produce negative interactions. Therefore they should be told of any medications the patient is taking, including those that provide treatment for HIV.

### PROTOCOLS AND TRAINING

Dentists, as well as other health care providers, should use standard infection control precautions at all times. The Centers for Disease Control and Prevention (CDC) has set forth the minimum infection prevention practices that apply to patient care for blood-borne and airborne pathogens. Staff should be educated about these pathogens and undergo training so that they can take precautions to prevent transmission.

The standard precautions to be observed include the following:

- Practice hand hygiene.

- Wear personal protective equipment, which includes gloves, masks, and eyewear.
- Observe respiratory hygiene/cough etiquette behaviors.
- Handle sharps safely.
- Practice safe injection techniques.
- Clean and disinfect environmental surfaces.

Staff may be hesitant or actually refuse to treat patients with HIV. The Dentists Insurance Company (TDIC) recommends that all staff members attend training courses and classes that address HIV transmission and proper barrier procedures. If staff members continue to refuse to provide care for an HIV-positive patient, disciplinary action may be required. Such a refusal is not a defense in a discrimination claim against an employer.

### CONFIDENTIALITY ISSUES

A patient's HIV status carries special confidentiality protections. Dental staff must not release the information without express written permission from the patient or his or her legal representative. Some states do not recognize a general release or records form for HIV status unless the release specifically states that HIV status is included.

The dental office should include these issues in the practice's privacy protocol manual and ensure that all staff members are aware of the policy. Patients can then be reassured that

#### Clinical Significance

The owners of a dental practice should be aware of their responsibility to follow antidiscrimination policies, which are outlined in state and federal laws. In addition, they should train staff to consider all patients as infectious and use standard infection precautions in all situations, which will avert a possible liability claim.