Assigning a risk for the development of oral disease

Points to consider in the development of a personal care plan

Variation in personal care plans for the three overall risk levels

- **High Risk**
  - Disease present?
  - Are any risk factors present?
  - Enhanced Prevention
  - Interventive treatment and/or referral, if required
  - Short interval: Focussed Oral Health Reviews to check risk areas, compliance and review recall interval
  - Minimum interval of 3 months between reviews
  - Oral Health Assessment at 24 months for adults, 12 months for children

- **Medium Risk**
  - Disease present?
  - Are any risk factors present?
  - Enhanced Prevention
  - Interventive treatment and/or referral, if required
  - Medium interval: Focussed Oral Health Reviews to check risk areas, compliance and review recall interval
  - Minimum interval of 6 months between reviews
  - Oral Health Assessment at 24 months for adults, 12 months for children

- **Low Risk**
  - Disease present?
  - Are any risk factors present?
  - Standard Prevention
  - Patient preferences and expectations
  - Clinical Findings
  - Diagnosis and Risk Assessment
  - Care Options (e.g. patient advice, preventive, treatment, maintenance, referral)
  - Short interval: Focussed Oral Health Reviews to check risk areas, compliance and review recall interval
  - Minimum interval of 6 months between reviews
  - Oral Health Assessment at 24 months for adults, 12 months for children

Note that for a new patient assessed as low risk, a conservative interval for Focussed Oral Health Reviews is advised initially which can be extended incrementally if no new problems are encountered.
Modifying Factors

Modifying factors include risk and protective factors, behaviours and clinical findings that may be identified from patient histories or the assessment of oral health status. These factors are associated with the development of oral disease and conditions and should be considered when determining the risk-based frequency of Focussed Oral Health Reviews.

Patient Histories
- Conditions that increase a patient’s risk of developing dental disease (e.g. diabetes, xerostomia as a result of, for example, Sjögren’s syndrome, certain drugs or head and neck radiation therapy)
- Conditions that might complicate dental treatment or the patient’s ability to maintain their oral health (e.g. special needs or anxious, nervous, phobic conditions)
- Conditions where dental disease could put the patient’s general health at increased risk (e.g. patients on warfarin, immunosuppression)
- Excessive alcohol use (>21 units of alcohol per week for men; >14 units of alcohol per week for women)
- Family history of chronic or aggressive (early onset/juvenile) periodontitis
- History of early tooth loss due to periodontal disease
- High % of bleeding on probing in relation to a low plaque index
- Poor level of oral hygiene
- Residence in a deprived (low SIMD) area
- Use of other sources of fluoride or resident in a water-fluoridated area (protective factor)

Head and Neck
- Craniofacial abnormalities
- Limited mouth opening
- Neck (lymph node) swelling
- Suspicious skin lesions (basal or squamous cell carcinomas, melanomas)
- TMD problems

Oral Mucosal Tissue
- Betel quid chewing
- Diets low in fruit and vegetables
- Excessive alcohol use (>21 units of alcohol per week for men; >14 units of alcohol per week for women)

Periodontal Tissue
- Bony loss observed on sequential radiographs
- BPE scores of 3,4,* in patients under 35 years of age
- Concurrent medical factor that is directly affecting the periodontal tissues (e.g. diabetes, stress, certain medication)
- Evidence of gingivitis
- Family history of chronic or aggressive (early onset/juvenile) periodontitis
- Family history of early tooth loss due to periodontal disease
- High % of bleeding on probing in relation to a low plaque index
- Poor level of oral hygiene
- Presence of plaque-retaining factors
- Previous history of treatment for periodontal disease
- Rapid periodontal breakdown >2mm attachment loss per year
- Root morphology that affects prognosis
- Smoking >10+ cigarettes a day

Dental Caries
- Anterior caries or restorations
- Healthcare worker’s opinion (esp. children)
- Heavily restored dentition
- High and/or frequent sugar intake
- High caries rates in mother and siblings (applies to children only)
- High and/or frequent dietary acid intake
- High and/or frequent sugar intake
- Poor dietary behaviours
- Poor level of oral hygiene
- Premature extractions because of caries
- Previous carious experience
- Resident in an area of deprivation
- Use of a 1000 ppm fluoride toothpaste (protective factor)
- Use of other sources of fluoride or resident in a water-fluoridated area (protective factor)

Tooth Surface Loss
- Bruxism
- Clinical evidence of tooth wear
- High and/or frequent dietary acid intake (e.g. high consumption of acidic drinks such as carbonated drinks, citrus fruit and fruit juices)
- Predisposing medical and drug factors: for example, impaired salivary production or buffering ability, gastric reflux (often associated with Hiatus haemorrhagic oesophagus)
- Rapid progression of tooth wear
- Stress and/or anxiety

Tooth Abnormalities
- Family history
- Tooth abnormalities (tooth number, size, shape, colour)

Fluorosis
- Eating/disclosing toothpaste habit
- Exposure to fluoridated water, in conjunction with other factors, up to 3 years of age
- Inappropriate use of fluoride supplements or toothpaste
- Unsupervised toothbrushing (under 6 years)

Orthodontic Status
- Canine in the line of the arch but failing to erupt, 10–13 years of age
- Failure of teeth to erupt at the expected time
- First permanent molars of poor prognosis when hypodontia or skeletal discrepancy present
- Palatally ectopic or buccally impacted canines
- Patients requiring orthodontics as part of a multidisciplinary treatment plan

Dentures
- Poor denture and oral hygiene

Modifying factors are listed in alphabetical order.