

ORIGINAL ARTICLE

A prospective study to evaluate a new dental management protocol before hematopoietic stem cell transplantation

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Pre-hematopoietic stem cell transplantation (HSCT) dental treatment is essential to prevent serious infections from oral sources during immunosuppression, in patients who undergo HSCT therapy. This study was planned to establish a dental management protocol for such patients. Forty-one patients scheduled for HSCT to treat hematological malignancies were consecutively enrolled in the prospective trial. The dental status of all patients was evaluated by clinical and radiographic examination at a median of 47 days before the commencement of HSCT therapy. Thirty-six patients had one or more dental diseases; the remaining five had none. Caries was found in 26 patients, apical periodontitis in 19, marginal periodontitis in 24 and a partially erupted third molar in 11. Our policy is to preserve patients' teeth whenever possible, and therefore minimal dental intervention was planned. Treatment was completed for all 36 patients with dental pathologies, before the conditioning regimen began. All patients received the scheduled HSCT therapy without alteration, interruption or delay, and did not show any signs or symptoms associated with odontogenic infection while they were immunosuppressed. This protocol, therefore, appears to be appropriate for the pre-HSCT dental treatment of patients with hematological diseases.

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Introduction

Hematopoietic stem cell transplantation (HSCT) has become an essential treatment for many patients with malignant and non-malignant hematological diseases, including acute and chronic leukemias, aplastic anemia,

myelodysplastic syndromes and lymphomas.^{1,2} Although HSCT is an effective treatment modality for these patients, successful engraftment after HSCT requires adequate immunosuppression of the recipient, which is accomplished with total body irradiation, chemotherapy or a combination of both. Their immunosuppressed status makes the patients more susceptible to infection, resulting in an increased risk of infectious complications, including the development of severe septicemia, that may be life-threatening.^{2,3}

The oral cavity is a potential site of such infectious complications in patients receiving HSCT therapy, because it is an important port of entry for agents that can cause systemic infections.^{4–7} To prevent these oral complications, pre-transplant comprehensive oral care has been incorporated into the preparatory steps for patients scheduled to receive HSCT therapy. This approach is supported by the National Institute of Health consensus statement on oral complications of cancer therapy (1989), which states, 'dental foci are potential sources of systemic infections that need to be eliminated or ameliorated before commencement of anticancer therapy'.⁸ Therefore, to prevent significant morbidity, all sources of potential infection should be identified upon pre-transplant dental screening and treated appropriately.^{2,9,10}

Not all previous studies have supported a need for pre-HSCT dental treatment. Melkos *et al.*¹¹ reported that there was no significant difference in the occurrence of infection originating from oral disease during and after HSCT therapy between patients, with and without pre-HSCT dental treatments, but they did not describe in detail the severity of the dental diseases of the patients in their study. Toljanic *et al.*¹² demonstrated that oncologic treatment outcomes were unaffected by the presence of chronic dental disease or acute exacerbations of these disease states in a pilot study in which no chronic dental diseases were treated regardless of severity, but the great majority of the patients in their study received only chemotherapy, which does not require the serious immunosuppression needed for HSCT therapy. Given the limitations of these studies, pre-HSCT dental therapy is still indicated to prevent odontogenic complications.

The potentially complicating oral conditions that have been identified are as follows: dental caries, pulpitis, apical and marginal periodontitis and partially erupted third

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molar. Dental care for these disorders includes tooth brushing instruction, scaling, restoration, pulpectomy and endodontic treatment. Tooth extraction is recommended for severe dental disease. Such pre-HSCT dental treatments are anticipated to decrease the risk of local and systemic odontogenic infections during patient immunosuppression.

Considering the limited period available for pre-HSCT dental treatment,¹³ minimal dental intervention to treat only the sources of potential infection is recommended. However, treatment protocols that clearly define the best treatment modality for patients at their pre-HSCT dental assessment are needed. We previously used retrospective data to construct a brief dental management protocol for patients scheduled to undergo HSCT therapy for hematologic diseases and evaluated its usefulness.¹⁴ However, a protocol defining the appropriate detailed treatment modality according to the severity of each dental disorder remains to be described. This study was prospectively carried out to establish detailed treatment criteria for minimal intervention in potentially detrimental dental disorders and to judge the effectiveness of the protocol.

Patients and methods

Seventy-one candidates for HSCT therapy were referred from the Division of Hematology, Tsukuba University Hospital to the Division of Oral and Maxillofacial Surgery, which is the same hospital that carried out the screening of dental pathology between 1998 and 2004. Of 71 patients with hematological malignancies, 41 underwent HSCT therapy; 30 did not because their general condition was poor or because no appropriate donor could be found. The 41 patients were consecutively enrolled into the prospective trial. Subjects were 22 males and 19 females, ranging in age from 17 to 58 years with a mean of 41.3 years. All participants gave informed consent before proceeding with treatment. Hematologic diagnoses were as follows: 14 patients had chronic myeloid leukemia, seven had malignant lymphoma, four had acute myeloid leukemia, four had non-Hodgkin's lymphoma, four had myelodysplastic syndrome, three had multiple myeloma, three had acute lymphoblastic leukemia and two had other malignancies. Hematopoietic stem cells were collected from the bone marrow of 28 patients and from the peripheral blood of 13 (Table 1).

The dental status of all patients was evaluated at the initial visit before HSCT by one experienced dentist. The screening examination consisted of a clinical examination of the hard and soft oral tissues and a radiographic survey, including panoramic and occasional periapical films for symptomatic teeth. All dental diseases encountered, including caries, apical periodontitis, marginal periodontitis and impacted third molar, were recorded for each patient. Dental foci were defined as caries, apical and marginal periodontitis and partially erupted third molar.

A new protocol was designed to preserve diseased teeth whenever possible, compared with the previous protocol¹⁴ (see Figure 1). This protocol defines the pre-HSCT dental treatment modality for the dental foci identified, taking

Table 1 Oncologic diagnosis and medical treatment

	<i>No. of patients</i>
<i>Disease</i>	
CML	14
ML	7
AML	4
NHL	4
MDS	4
MM	3
ALL	3
Others	2
<i>Medical treatment</i>	
BMT	28
PBSCT	13

Abbreviations: ALL = acute lymphoid leukemia; AML = acute myeloid leukemia; BMT = bone marrow transplant; CML = chronic myeloid leukemia; MDS = myelodysplastic syndrome; ML = malignant lymphoma; MM = multiple myeloma; NHL = non-Hodgkin's lymphoma; PBSCT = peripheral blood stem cell transplant.

into account a patient's status and treatment schedule. We describe the details of the protocol below:

Teeth with mild or moderate caries are restored in patients with sufficient time for dental treatment, but observed in those with insufficient time. Decayed teeth with pulpitis are treated by pulpectomy and root canal filling. The residual roots are extracted.

Teeth with recently symptomatic apical periodontitis or asymptomatic apical periodontitis and periapical radiolucency of the maximal diameter greater than 5 mm are treated with root canal in patients whose schedule permits, but the teeth are removed if there is insufficient time for treatment. Asymptomatic apical periodontitis with periapical radiolucency of less than 5 mm is not treated.

Marginal periodontitis, teeth with gingival swelling, pain and purulent discharge, a probing depth greater than 8 mm or severe mobility are removed, whereas teeth with marginal periodontitis but without these signs and symptoms are observed and tooth brushing instruction and/or scaling is provided.

Partially erupted third molars with pericoronitis or purulent drainage are extracted, and asymptomatic third molars are not treated.

All patients, including those without dental foci, are given tooth brushing instructions to exfoliate dental plaque.

For the HSCT procedure, all patients were admitted to a disinfected room. During the conditioning period, each patient experienced at least one episode of a temperature higher than 38°C and an absolute white blood cell count (WBC) of less than 1000/ml lasting several days, as manifestations of their immunosuppressed status. Dental follow-up was conducted during the only HSCT hospitalization, which was approximately 3 weeks long. Any patient with local signs and symptoms consistent with odontogenic infections, such as swelling, pain, redness and sensitivity of the gingiva surrounding the teeth had a dental consultation and was given treatment as necessary. The frequency and occurrence of oral complaints and complications were recorded on the patients' medical charts and

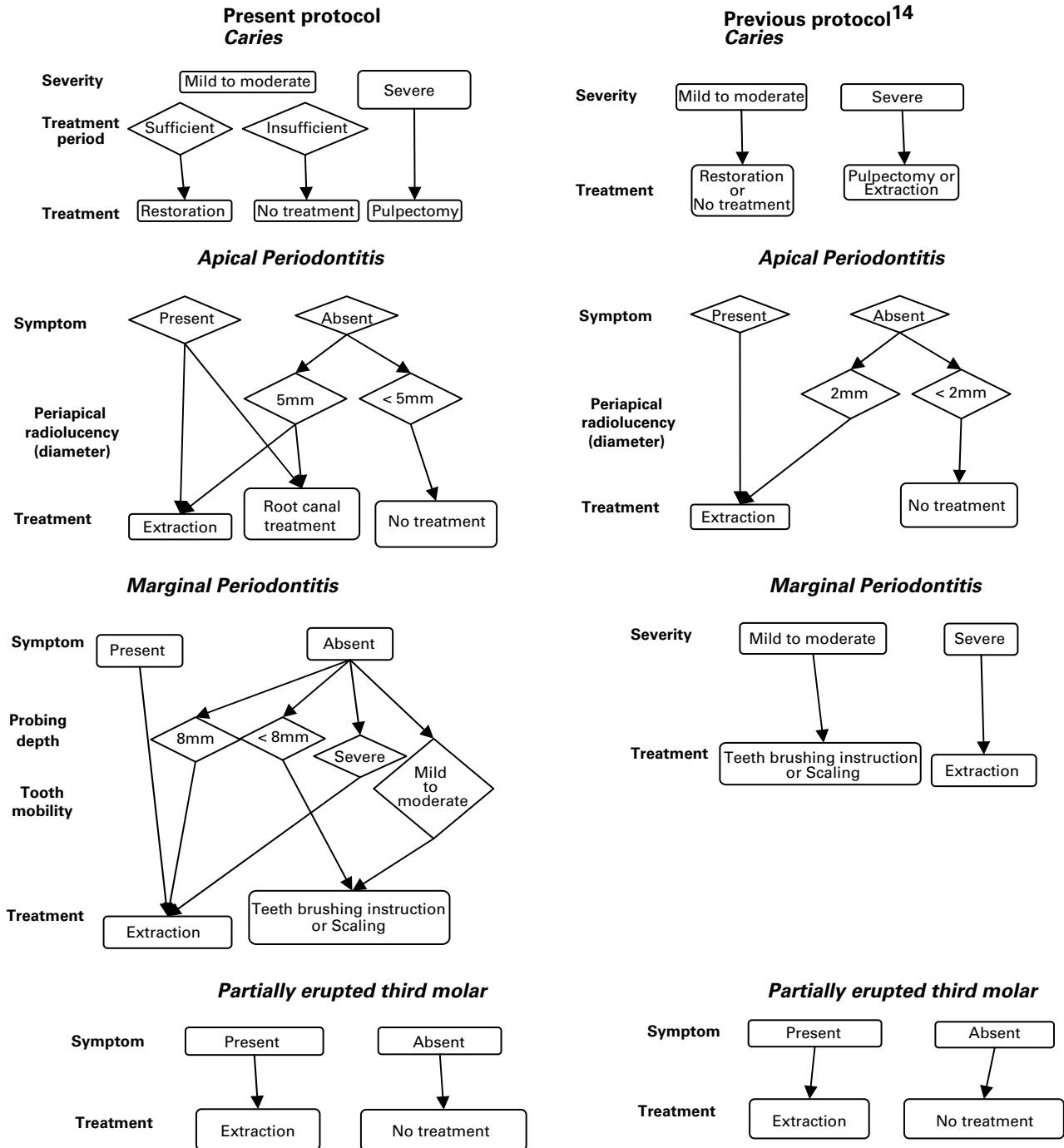


Figure 1 Dental treatment protocol for HSCT candidates.

investigated throughout the course of HSCT therapy, and the effectiveness of the new detailed protocol was assessed by the attending dentists and hematologists.

Results

The dental status of all patients was evaluated between 7 and 240 days before the commencement of HSCT therapy, with a median of 47 days. Dental treatment was required to

be completed 10 days before HSCT therapy, to give the patient time to undergo the conditioning regimen for HSCT. The time available for dental treatment was less than 1 month for 13 patients, from 1 to 2 months for 11, from 2 to 3 months for seven and more than 3 months for 10. The patients with duration of more than 2 months between dental examination and the commencement of HSCT therapy were re-examined to check for new dental disease within 1 month before HSCT therapy. Thirty-eight of the 41 patients (92.7%) had one or more dental diseases.

Table 2 Dental diseases

Dental disease	No. of patients ^a	No. of teeth
Caries	26	101
Pulpitis	2	5
Apical periodontitis	19	43
Marginal periodontitis	24	94
Partially erupted third molar	11	21

^aMore than one odontogenic disorder was diagnosed in some patients.

Table 3 Dental treatment outcome

Dental treatment	No. of patients	No. of teeth
Restoration	12	40
Scaling	24	
Professional tooth brushing instruction	21	
Extraction	10	14
Apical periodontitis	7	7
Marginal periodontitis	5	6
Partially erupted third molar	2	3
Pulpectomy	2	5
Endodontic treatment	4	5

Caries was discovered in 101 teeth in 26 patients, pulpitis in five teeth in two patients, apical periodontitis in 43 teeth in 19 patients, marginal periodontitis in 94 teeth in 24 patients and partially erupted third molar in 21 teeth in 11 patients (Table 2). Three patients had no dental disease.

Using the new protocol, 36 patients received one or more kinds of dental treatment. Of 101 caries in 26 patients, 40 cases in 12 patients were restored, and the remaining 61 teeth of 14 patients were not treated. All five cases of pulpitis were treated with pulpectomy and root canal filling. Of 43 teeth with apical periodontitis in 19 patients, 41 were asymptomatic and two were symptomatic. Periapical lesions greater than 5 mm were observed in 10 teeth in eight patients and lesions smaller than 5 mm in 33 teeth in 11. Seven teeth with asymptomatic lesions greater than 5 mm in seven patients were removed, five teeth in four patients, including two that were symptomatic and three that were asymptomatic, that had a lesion of over 5 mm were treated endodontically, and the remaining 31 teeth in 13 patients with asymptomatic apical periodontitis and periapical lesions of less than 5 mm were followed without treatment. Of 94 teeth affected with marginal periodontitis, six teeth of five patients were removed, and the remaining 88 teeth of 24 patients were preserved with scaling and professional tooth brushing instruction. Only three of 21 partially erupted third molars were symptomatic. One patient had two symptomatic lower third molars. All three symptomatic teeth were extracted, and eight upper and 10 lower asymptomatic third molars were not treated (Table 3). The planned dental treatment was completed for 36 patients before initiation of the conditioning regimen. There was no new dental pathology at re-examination. All 41 patients, including the five that did not require dental treatment, underwent HSCT therapy without showing signs or symptoms associated with odontogenic infection.

The median number of days in which patients' temperature was higher than 38°C during HSCT was 4, ranging from 0 to 60 days, with no significant difference between bone marrow transplantation (BMT) and peripheral blood stem cell transplantation (PBSCT). The median number of days where patients had a WBC of less than 1000/ml was 17, ranging from 6 to 75 days for BMT, and 10 ranging from 0 to 12 days for PBSCT. There was a statistical difference in the number of days of WBC less than 1000/ml between the two HSCT modalities.

Only two of the 41 patients (4.9%) experienced gingival pain before and during HSCT therapy. One was a 31-year-old female who complained of mild pain at the lower anterior gingiva, where gingivitis had been induced by anticancer agents. Another was a 30-year-old male who complained of mild pain at the gingiva of the upper third molar, which was under observation as asymptomatic. In both cases, there were no symptoms except pain, and there was no possibility of odontogenic infection. Pain resolved spontaneously in both patients without treatment, and the scheduled HSCT therapy continued. Thus, no alteration, interruption or delay of HSCT therapy was required for any patient.

Discussion

Pre-HSCT dental screening to identify and treat potential oral sources of infection has become standard care in patients scheduled for HSCT therapy.^{3,7} The principal aim of screening is to reduce morbidity and mortality, which may arise from oral complications associated with HSCT therapy during immunosuppression. Although all potential sources of oral infection should be eliminated by dental treatment before initiation of conditioning, time limitations and the patient's disease status frequently interfere with complete treatment.^{3,6,7,13} Given this restriction, the removal of potentially preservable diseased teeth may be the only viable treatment option, resulting in oral care that does not best serve the long-term oral needs of the patients, because removal of multiple teeth may compromise nutrition during and after HSCT therapy.¹⁵ As a further complication of extraction, there is an associated increased risk of infection, bleeding or delayed wound healing that could require postponing the scheduled HSCT therapy.¹⁶⁻¹⁸

A comparison between patients with no dental foci or completed dental treatment and those with dental foci or no dental interventions demonstrated that the impact of dental foci on the occurrence of post-HSCT infections was not statistically significant.¹¹ Patients with chronic dental pathology were reported to be safe to proceed with chemotherapy without dental intervention, as the conversion of chronic dental disease to an acute state during chemotherapy occurs infrequently.¹² These reports suggest that intensive pre-HSCT dental treatment is not necessary. Furthermore, patients should avoid the additional morbidity or mortality associated with needless treatment. Consequently, minimal dental intervention is recommended.

Our previous dental management protocol was evaluated as significantly beneficial as pre-HSCT dental treatment for patients scheduled to undergo HSCT therapy, but included

removing potentially salvageable teeth to prevent the occurrence of infection during the therapy.¹⁴ From our experience and the desire to preserve teeth if possible, we designed a new protocol for minimal intervention, in which the treatment modality is decided according to the severity of the disease, and only severely diseased teeth are extracted. The time available to treat dental disorders in the current study was longer than in other reports,¹³ resulting in the completion of planned dental treatments before conditioning in all patients. It is important that the planned treatment be completed before HSCT therapy, even if minimal dental intervention is adopted, so early dental screening and treatment is essential. However patients with a duration of more than 2 months between dental examination and commencement of HSCT therapy had the possibility of developing new dental disease after dental examination. We therefore considered that re-examination should be carried out in order to identify new dental disease within 1 month before HSCT therapy.

Most studies and the current protocol agree concerning treatment modality for caries, symptomatic periapical lesion, severe advanced marginal periodontitis and symptomatic partially erupted third molar.^{3,7,17,19,20} However, considerable controversy remains as to the best treatment for asymptomatic periapical lesion, chronic marginal periodontitis and asymptomatic partially erupted third molar, and practitioners manage these pathologies with approaches that vary from very conservative to aggressive.

As regards asymptomatic apical periodontitis, one study suggests that there is no increase in the incidence of infectious complications during HSCT therapy when teeth with post-endodontic periapical radiolucencies of greater than 1.5 mm are not treated.¹⁹ Our previous study also showed that untreated periapical radiolucencies smaller than 2 mm did not convert to the acute stage during HSCT therapy.¹⁴ However, treatment is commonly required for large periapical lesions in the healthy population. In the present study, we did not treat asymptomatic periapical periodontitis with apical radiolucencies that were smaller than 5 mm, and there was no occurrence of conversion to the acute stage or of infectious complications. Patient outcomes in the present study suggest that it is safe not to treat asymptomatic apical lesions smaller than 5 mm before immunosuppressive conditioning.

Chronic marginal periodontitis is the most common significant dental infection, which affects HSCT patients.^{4,6,21} A retrospective investigation reported that 64% of patients with chronic periodontal disease had positive blood cultures associated with clinical signs of septicemia during the initial 100 days after HSCT.¹⁵ However, because little data are available about the effect of pre-HSCT dental treatment for chronic periodontitis on the incidence of infectious complications, the treatment modality has varied from observing the affected teeth to removing asymptomatic teeth.^{22–24} Teeth with a poor periodontal prognosis are generally extracted, but no relationship has been found between radiographic periodontal status and the incidence of septicemia.¹⁵ In the present protocol, only symptomatic teeth with acute conversion, a probing depth greater than 8 mm, or severe

mobility were extracted; teeth without these symptoms were treated with scaling, and the patient was instructed in proper brushing technique. There was no occurrence of infectious complications in these patients. These outcomes indicate that teeth with chronic marginal periodontitis, except for actively infected teeth, can be treated conservatively.

There are two basic treatment options for managing an impacted, asymptomatic third molar. Some advocate prophylactic extraction as soon as possible,^{22,25} whereas others prefer a more conservative approach,^{17,26} because the risk of developing diseases associated with the third molar may be further reduced if the patient has good oral hygiene. In one study, 40% of patients who underwent prophylactic removal of partially erupted or impacted third molars, which were symptomatic or asymptomatic, experienced post-operative complications, such as bleeding, alveolitis, trismus or infection, in the course of intensive cancer therapy, including BMT.¹⁷ The complication rate among these patients was much higher than that reported in the healthy population.²⁷ In that report, the symptoms of most non-extracted symptomatic third molars were treated with antibiotics and analgesics, but the impact on outcome of scheduled HSCT therapy was not described. In the current protocol, symptomatic third molars were removed, and asymptomatic third molars were untreated, and there was no occurrence of odontogenic infection.¹⁷ Outcomes using this management approach indicate that extraction for symptomatic third molars and non-intervention for asymptomatic ones is safe.

After completing dental treatments, which followed the newly designed protocol, all the patients received their scheduled HSCT therapy without alteration, interruption or delay, and did not experience signs or symptoms associated with odontogenic infection during immunosuppression. Consequently, the new protocol is likely to be appropriate for guiding the pre-HSCT dental treatment of patients with hematological diseases.

Some studies report that systemic oral assessment, regular encouragement of patient self-care, and consistent oral care may be the most important factors related to the prevention or amelioration of oral infection during HSCT therapy.^{7,21,28} In addition to the management of oral diseases, patient caregivers should provide careful instruction in advance about oral care during immunosuppression. Before dental treatment, all patients in the present study were educated to exfoliate dental plaque, which produces dental caries and marginal periodontitis. The extent to which dental instruction influenced the absence of oral infection in the present study is unknown, but we believe the instruction was beneficial. Further studies with a larger sample are required to confirm the appropriateness of the newly designed dental treatment protocol.

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