IN BRIEF

- Most patients requiring oral surgical care may be safely and appropriately treated in the primary health care setting.
- There is a real risk of the broad clinical remit of oral surgery provision in the primary health care setting being restricted.
- Working as a team with adequate funding, dentists with special interests and specialists in oral surgery can improve the access of patients to specialist care.

Primary care-based oral surgery: an audit

An audit of 600 referrals to a primary care based oral surgery service **G. Bell¹**

ABSTRACT

Aim

To identify potential problems in the quality of care when oral surgery is provided in the primary health care setting.

Method

Retrospective analysis of referral patterns, waiting times, treatment with clinical and histological diagnosis, including complications of 600 patients referred to a practice-based oral surgical referral service.

Results

Fifty-three patients were not treated. Seventy-nine percent of patients were treated within four weeks of referral. The most common procedure performed was surgical removal of impacted third molar teeth. The most frequently observed complications were dry socket ($n = 31/703$), pain and inflammation associated with resorbable sutures ($n = 11/453$), and post-operative infection ($n = 9/547$). One patient with post-operative infection required care in the acute hospital setting.

Conclusion

Acknowledging the small sample, it was safe and effective to diagnose and treat a broad spectrum of patients and oral surgical problems in the primary health care setting.

EDITOR'S SUMMARY

This paper by Bell provides a useful and interesting audit of the success and quality of care provided by a primary care-based oral surgery referral service. As the author points out, oral surgery provided in the primary care setting is far less common in the UK than in most of Europe. This audit concluded that it was safe and effective to treat patients requiring a variety of oral surgical treatments in primary care. Although the sample size was small and had different clinical and demographic features to those of most secondary care oral surgery units, these results are nonetheless important to note, particularly in the current climate of improving patient choice.

The centre on which the study focused was, as pointed out in Dr Rice's commentary (right), well-established and resourced, and was financed by patients paying privately for their treatment. The author states that 'It had not been possible to obtain satisfactory terms of NHS provision' and unfortunately this is likely to be the case for most of such services. As highlighted by the author in his discussion, a sea change in the philosophy of specialist and general dental practice would be required in order to enable NHS oral surgery specialists to provide a comprehensive primary care service. This study suggests there is a demand from patients for such services, and a well-organised system could help to ease pressure on hospital-based oral surgery units. However, if we are ever to witness the changes required, more studies like this one are needed together with further investigations into every aspect and possible consequence of oral surgery in primary care.

The full paper can be accessed from the *BDJ* website (www.bdj.co.uk), under 'Research' in the table of contents for Volume 203 issue 3.

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FULL PAPER DETAILS

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AUTHOR QUESTIONS AND ANSWERS

1. Why did you undertake this research?

This audit was prompted following concerns expressed by colleagues in relation to the appropriate setting for the provision of an oral surgery service and their perception of lack of clinical governance.

2. What would you like to do next in this area to follow on from this work?

Access to specialist care is dependent upon patients' access to primary care based general practitioners and it is largely the choice of those practitioners whether medical or dental as to where referrals for specialist care are made.¹⁻³

Having demonstrated that the most frequently provided surgical procedures involving the oral cavity can be safely provided in the primary health care setting the intention is to investigate the potential referral base of the oral surgery specialist in providing a comprehensive diagnostic and therapeutic service for orofacial pain and diseases / lesions of the oral soft tissues. The next step is therefore to study patients' perceptions of medical and dental practitioners in terms of training and ability to treat oral disease and their choice of primary care practitioner for various orofacial symptoms.

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2. Cottrell DA, Reebye UN, Blyer SM, Hunter MJ, Mehta N. Referral patterns of general dental practitioners for oral surgical procedures. *J Oral Maxillofac Surg* 2007; **65**: 686-690.
3. McArdle PJ, Whitnall M. The referral practice of general medical practitioners to the surgical specialties: implications for the future. *Br J Oral Maxillofac Surg* 1996; **34**: 394-399.

COMMENT

Delivering an 18 week patient pathway from referral to the start of treatment by the end of 2008 is a key objective for the NHS. This paper is therefore particularly timely in retrospectively examining referral patterns, treatment times and treatment within a practice-based oral surgery service. The author has reviewed 600 consecutive private referrals for a range of procedures, the vast majority of which are exodontia. The results show that the majority of patients (96%) were treated within ten weeks of referral. Most were medically fit and well with 96% being ASA grade 2 or above. Clearly, this suggests that the demographics of the patient base differ from those seen in many oral and maxillofacial units and the author alludes to this in his conclusion.

The results show that of the 600 referrals, 53 patients were deemed inappropriate for local treatment. Where treatment was carried out, 392 were performed under intravenous sedation. The most frequently performed procedures were removal of third molar teeth, other exodontia and root end surgery. Of note, there were 20 soft tissue biopsies undertaken and analysis of the histopathological results reveal a range of benign conditions. This is an area of some debate as there is a possibility that an added tier of primary care referral may delay treatment of malignant disease. There were 59 documented post-operative complications, the most common being dry socket. Significantly, one patient required hospital admission for post-operative infection.

In conclusion, this paper suggests that there is demand for specialist oral surgery services in primary care and demonstrates a well-resourced and established centre. The author should be congratulated for a well constructed retrospective audit. However, as the author concludes, it is a small sample with differing clinical and demographic features to many oral surgery units. Further investigation is clearly needed to establish service frameworks and address clinical governance issues within NHS practice.

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