Top tips for management of patients with dementia in primary care: Part 2

By Charlotte Curl[1] and Ewen McColl[2]

Introduction

Dementia is one of the biggest health challenges facing the NHS. In the UK, there are currently 944,000 people living with dementia and it is estimated that there will be 1.6 million people living with dementia in the UK by 2050. In the previous article, we discussed some practical tips for managing such patients in general dental practice. In part two, we discuss clinical management as the illness progresses.

Top management tips

Care planning for people living with dementia

When planning dental care for people living with dementia, it must be noted that dementia is a degenerative disease and there will be a decline in oral and general health as the disease progresses.

The first approach should be to establish the overall aim in treatment; this will vary dependent on whether the treatment is urgent or elective and should be established in conjunction with the patient +/- carer. The stage of dementia must be considered as this relates to the patient's symptoms, capacity to consent to dental treatment, ability to cope with treatment, oral hygiene procedures and dietary intake.[1]

It is helpful to classify a patient according to the stage of the dementia as described by the World Alzheimer Report: Early, Middle or Advanced.[2]

Treatment in early stages of dementia

Most patients with early dementia will access dental treatment at a general dental practice and may not require additional support from carers. In many respects, the input from dental professionals at the earliest stages of the disease is the most important as it can pre-empt and prevent future dental pain and infection.

In the early stages, a decline in oral and general health will be anticipated and decisions about future care may be had with the patient while they still can reason effectively. The process whereby a patient's wishes are recorded to preserve autonomy when they lose capacity to make their own decisions is called advanced care planning.[3]

Questions that may be addressed in an advanced care plan are:

- What matters most for them in dental care?
- If they have toothache, would they prefer to have an extraction or attempt to save the tooth?
- How important is it for them to keep all of their front teeth?
- Are they happy to have gaps in their mouth if teeth are extracted or would they want to have something to fill the gap?
- Would they like to have dentures if they have missing teeth?

Recording of a patient's preferences can help to ensure that any decisions about dental care made under a best interests decision align with their values or wishes as specified in the Mental Capacity Act.[4]

The aims of treatment in the early stages are to eliminate and prevent pain, control infection and prevent new disease. At this stage, most restorative and rehabilitative care is possible. Treatment should be planned anticipating the person's decline in cooperation and ability for self-care. A full dental assessment should be carried out including radiographs and periodontal screening. High quality restorative work should be completed that requires low maintenance as the disease progresses and oral hygiene becomes more difficult to maintain. Key teeth can be identified (eg canines, molars, occluding pairs) and restored to function.[5]

'Aggressive prevention' and regular recall has been recommended at this stage.[6] Examples of aggressive prevention may include:

- Custom-made mouthguards with reservoirs which can be loaded with standard 1450 ppm fluoride toothpaste and worn overnight or for a couple of hours per day[7]
- Adaption of oral hygiene aids, for example adaption of toothbrush handles with impression putty so that they can be gripped more easily when dexterity becomes impaired
- Six-monthly application of fluoride varnish to the teeth
- Prescription of high fluoride toothpaste to be used twice daily.

In the early stages of dementia, well-fitting dentures should be constructed that teeth can be added to in the future in the event that further teeth are lost. It is advisable that dentures are marked with the patient's name during the construction process as people living with dementia often lose dentures, particularly in care homes.[8]

Treatment in the middle stages of dementia

In the middle stages of dementia, patients may still access dental treatment from their general dental practitioner with support from informal/formal carers but it may be necessary to refer them to specialist services who offer treatment under sedation or general anaesthesia if co-operation has become impaired and they require more than a check-up appointment.

'Aggressive prevention' and regular recall appointments must be continued and carers will be relied on more to help with oral hygiene procedures and encourage self-care. It is useful to carry out periodontal assessments and radiographs where possible as these may highlight areas of periodontal bone loss and teeth of poor prognosis which may become more mobile as dementia progresses; it may be advisable to extract teeth of poor prognosis which will act increasingly as plaque traps as the disease progresses. Prevention is paramount and must be reinforced with the patient and carer. High fluoride toothpastes may be instituted and consideration given to a six-monthly application of a fluoride varnish.[9] Carers may be given specific training in how to support oral hygiene with the use of electric toothbrushes and personalised dietary advice.[10]

In the middle stages of dementia, mental capacity may be retained but may fluctuate daily so it is imperative that mental capacity

[1]Consultant in Special Care Dentistry and Dental Care Group Patient Safety & Governance Lead, King's College Hospital NHS Foundation Trust, King's College Dental Hospital, Denmark Hill, London SE5 9RS, UK; [2]Director of Clinical Dentistry, Peninsula Dental School (University of Plymouth), Derriford Dental Education Facility, Plymouth Science Park, Research Way, Plymouth, PL6 8BT, UK.

assessments are carried out and recorded and patients are given extra support so that they remain involved in any decision-making about their care.

Dental treatment in the advanced stages of dementia

In the advanced stages of the disease, the goal of the dental practitioner is to diagnose and manage dental pain and support the maintenance of oral hygiene. The diagnosis of pain may become difficult as cognitive function declines and frequently patients are assessed as not having the capacity to give informed consent to dental treatment or even understand what is happening as treatment is carried out. Some patients can be more comfortable and lucid in their own home environments[11] and screening, examination and simple treatment could be carried out on a domiciliary basis rather than in a dental practice.

Generally, the later stages of the disease pose the most challenges for the dental practitioner because the person living with the disease tends to be:

- Older
- More frail with an increasing number of co-morbidities
- Less able to communicate/express themselves
- Lacking capacity to consent to dental procedures or understand what is happening to them.

Dental interventions should be kept as non-invasive as possible; eg using Carisolv for caries removal, atraumatic restorative techniques (ART) such as glass ionomer cement restorations, regular use of chlorhexidine varnish to control root caries.[12]

If treatment is beyond the individual's coping capacity is required two questions need to be asked:

- Is the treatment necessary?
- How can it best be carried out?

In the absence of symptoms, treatment can offer a lesser benefit and can adversely affect aesthetics, masticatory function and quality of life,[13] so it may be better to leave some conditions untreated and merely monitor them over time. For example, it may be appropriate to retain asymptomatic retained roots/failing complex restorative treatment which would be complex to manage.

When making decisions about whether treatment should be carried out, the impact that the proposed treatment will have must be considered.

If it is deemed that the patient should have dental treatment carried out, the dental practitioner should only offer treatment if they feel that they are competent to do so and it may be necessary to refer the patient to Specialist Services. Often, patients living with advanced dementia will require sedation or general anaesthesia for dental treatment to be carried out but clinicians considering offering these treatment modalities must be aware of the physiological changes and commonly occurring diseases that are found in this age group which may affect the pharmacodynamics of drugs used for sedation or general anaesthesia.[14]

Conclusions

Clinicians will increasingly be faced with managing patients with dementia. In this series of two articles we have offered some practical steps and tips on how best to manage these most deserving of patients. Staying pragmatic and thinking laterally in order to provide practical outcomes will remain key and the advice in this series will hopefully help hard pressed clinicians in managing patients with dementia as they present more frequently in their practices. ■

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