

CLINICAL HINTS

REFERRAL FOR MINOR SURGERY

Stanley G. Jacobs

Kenneth Adamson Department for Orthodontia, The Royal Dental Hospital of Melbourne, 711 Elizabeth Street, Melbourne, Victoria 3000

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The following *check list* may aid the orthodontist in ensuring the smooth referral of a patient for a minor oral surgery procedure.

The referral letter should include:

1. Any significant dental, medical or social history.
 2. What to do e.g. 'please uncover 13' (the maxillary right permanent canine).
 3. The location of the teeth to be uncovered and what methods were used to determine their position e.g. by tube shift, tooth palpable, adjacent tooth position being influenced by the unerupted tooth.
 4. Any particular procedure required e.g.:
 - (a) for an unerupted labial maxillary canine - whether an apically repositioned flap procedure should be used during uncovering;
 - (b) for a mid-line supernumerary tooth and an unerupted maxillary central incisor - whether an apically repositioned flap is required, whether the incisor should be uncovered in addition to the removal of the supernumerary;
 - (c) for removal of a labial frenum - should the fibres which may be embedded in the intermaxillary suture be removed by burring into the suture between the teeth.
 5. Any other necessary extractions to be carried out at the same time as the surgical procedure so that repeated general or local anaesthetics are avoided, when possible (Hunter 1983).
 6. 'Radiographs enclosed' (specify what they are) and enclose appropriate radiographs.
 7. When the orthodontist wishes the procedure to be carried out, and when the patient will be seen again e.g. (a) 'please return patient to me when pack removed', or (b) 'patient has a further appointment in the orthodontic department in July, 1990'.
 8. If something is unusual e.g. if the orthodontist is uncertain whether a maxillary lateral incisor is being resorbed by an impacted canine and decides to extract the lateral incisor he may ask for the extracted incisor to be sent to him. This would enable the orthodontist to learn from the case by seeing the amount and direction of resorption.
- In a private practice environment it may be useful to also:
9. Request the return of the radiographs.

Comments

1. Re point 2.

To reduce the possibility of error it is advisable to write in words, as well as using FDI numbers, which teeth will be involved in any dental procedure.

2. Re point 5.

(a) The surgeon appreciates being informed what is planned for future management of the third molars (if impacted). Comments such as 'the fate of the third molars will be determined during retention and the patient has been informed that there is a strong likelihood that the third molars will need to be removed' are helpful to the surgeon. The surgeons are frequently questioned about repeat general anaesthetics.

(b) If a permanent canine is to be uncovered and the deciduous canine is present, mention should be made whether the deciduous canine should be removed at the time of uncovering or kept.

(c) Machen (1989) presented a composite case about the impacted canine in a series on 'risk management concepts'. The deciduous canine and all first premolars were extracted and the impacted maxillary canine uncovered. The maxillary canine was ankylosed, it did not move, eventually it was extracted and residual space remained. The case was settled for \$70,000. Machen suggested that litigation may have been avoided (i) by the use of a more conservative treatment plan i.e. by postponing the extraction of the first premolars until it can be seen that the maxillary canine is moving although this may significantly extend treatment or (ii) through effective informed consent i.e. thoroughly inform the patient/parent of possible complications and have them choose whether to assume the risk of proceeding with premolar extractions in order to avoid delay.

Jacobs (1989) detailed the case history of an ankylosed maxillary canine in a discussion of the ankylosis of permanent teeth.

3. Re point 6.

If insufficient radiographs have been taken the patient should be warned that more may be required.

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