Complete Summary

GUIDELINE TITLE

Dental recall - recall interval between routine dental examinations.

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Acute Care. Dental recall: recall interval between routine dental examinations. London (UK): National Institute for Clinical Excellence (NICE); 2004 Oct. 118 p. [153 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
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IDENTIFYING INFORMATION AND AVAILABILITY
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SCOPE

DISEASE/CONDITION(S)

- Dental disease, such as caries, periodontal disease, erosion, and tooth surface loss
- Oral disease, such as oral cancer and mucosal lesions

GUIDELINE CATEGORY

Evaluation
Prevention
Risk Assessment

CLINICAL SPECIALTY

Dentistry

INTENDED USERS

Dentists
Patients

GUIDELINE OBJECTIVE(S)

To help clinicians (including independent contractors within the National Health Service [NHS] dental hygienists and therapists) assign recall intervals between oral health reviews that are appropriate to the needs of individual patients

TARGET POPULATION

Patients of all ages (both dentate and edentulous patients)

INTERVENTIONS AND PRACTICES CONSIDERED

1. Oral health review including comprehensive history, examinations, and preventative advice
2. Review and discussion with patients of:
    - Lifestyle factors (oral hygiene, diet, fluoride use, tobacco, and alcohol)
    - Risk factors
    - Outcomes for previous care episodes
    - Desire/ability to visit the dentist
    - Financial costs to the patient
3. Choosing next oral health interval based on age; discussing this with the patient, and recording the agreed upon interval
4. Reevaluation of recall interval at next visit

MAJOR OUTCOMES CONSIDERED

- Primary Outcomes: Caries, periodontal disease, oral cancer, and quality of life
- Secondary Outcomes: Mucosal lesions, behaviour change, need for orthodontic treatment (In the updated review, erosion and tooth surface loss were included as secondary outcomes of interest).
- Clinical and cost-effectiveness of a dental recall examination
- Effectiveness of routine dental checks of different recall frequencies in improving quality of life and reducing the morbidity associated with dental caries, periodontal disease, and oral cancer

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Literature Search

The literature review for the guideline was designed to find references published since the completion of searching for the Health Technology Assessment (HTA) Report in February 2001. The search terms used in the HTA Report and some additional key words were used to form the basis of the search strategy. Search filters for systematic reviews, randomised controlled trials, and other observational studies were combined with this to retrieve quality studies. No language restrictions were applied to the search. The search strategies of the following databases are included in Appendix C of the original guideline document.

- Medline (Ovid) 2001 - 17 July 2003
- Embase (Ovid) 2001 - week 29 2003
- The Cochrane Library 2001 up to Issue 3, 2003

The guideline developers searched the System for Information on Grey Literature in Europe (SIGLE) and Health Management Information Consortium (HMIC) for reports, and they also searched for guidelines and consensus documents on the guideline Web sites listed in the original guideline document. Bibliographies of identified reports and guidelines were also checked to identify relevant literature.

Selecting Studies

Two reviewers independently scanned the titles and abstracts of the observational studies in order to identify potentially relevant studies. They excluded papers that were considered definitely irrelevant. Guideline developers obtained full publications for any studies identified by one or both reviewers as being of potential relevance to the review or where there was insufficient information from the title and abstract to make a decision. Two reviewers applied the inclusion criteria to all potentially relevant studies and any disagreements were resolved by discussion. No formal analysis of agreement between the reviewers was performed.

Literature Review of Published Economic Studies

The guideline developers obtained published economic evidence on different recall intervals for oral health review (OHR) from a systematic search of the following databases:

- Medline (Ovid) (2001-2003)
- Embase (2001-2003)
- Health Economic Evaluations Database (HEED)
- NHS Economic Evaluations Database (NHS EED)

The guideline developers also identified and reviewed relevant references in the bibliographies of reviewed papers including those from the HTA Report. They did not conduct original searches of Medline and Embase prior to 2001 as this would duplicate the systematic searches of the HTA Report.

The strategy was designed to find any applied economic study related to different dental recall intervals. The health economist reviewed abstracts and database

reviews of papers, and discarded those that appeared not to contain any original data on cost or cost-effectiveness and where the analysis was not incremental (and was not described adequately to allow incremental analysis).

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1++

- High-quality meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs with a very low risk of bias

1+

- Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias

1-

- Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias

2++

- High-quality systematic reviews of case-control or cohort studies
- High-quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal

2+

- Well-conducted case-control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal

2-

- Case-control or cohort studies with a high risk of confounding bias or chance and a significant risk that the relationship is not causal

3

- Non-analytic studies (for example, case reports, case series)

4

- Expert opinion, formal consensus

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Review of Published Meta-Analyses

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Data Extraction

One reviewer carried out the data extraction process. Data extracted from each study regarding the patient population, intervention, comparators and outcomes were used to construct two summary tables: a "Key Study Characteristics" table and an "Effectiveness table" (Appendix D in the original guideline document).

Quality Assessment

Two reviewers carried out the quality assessment of eligible studies using similar appraisal checklists to those used in the Health Technology Assessment (HTA) Report. The checklists were specific to study design with a view to capturing design-specific biases. Attempts to control for selection biases through adjustment for potential confounders were assessed.

As this guideline is intended to inform practice in the National Health Service (NHS) in England and Wales, the external validity of the results of studies carried out in settings other than the United Kingdom (UK) was also considered as part of the assessment.

Note from the National Guideline Clearinghouse: Refer to the "Cost Analysis" field for a description of the meta-analysis.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Delphi)
Expert Consensus (Nominal Group Technique)
Informal Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Guideline Development Group was presented with the summaries (text and evidence tables) of the best available research evidence to answer their questions. Recommendations were based on, and explicitly linked to, the evidence that supported them.

The Group worked, where possible, on an informal consensus basis. Formal consensus methods (modified Delphi techniques or nominal group technique) were employed if required (for example, agreeing recommendations and audit criteria). The recommendations were then graded according to the level of evidence upon which they were based.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Recommendation Grades

A

- At least one meta-analysis, systematic review, or randomized controlled trial (RCT) rated as 1++, and directly applicable to the target population, or
- A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B

- A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results, or
- Extrapolated evidence from studies rated as 1++ or 1+

C

- A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results, or
- Extrapolated evidence from studies rated as 2++

D

- Evidence level 3 or 4, or
- Extrapolated evidence from studies rated as 2+, or
- Formal consensus

GPP

- A good practice point (GPP) is a recommendation for best practice based on the clinical experience of the Guideline Development Group

COST ANALYSIS

The Health Technology Assessment (HTA) Report Model

The HTA Report model aimed to assess the cost-effectiveness of 3, 6, 12, 18, 24 and 36 monthly routine dental checks. Cohort simulations (Markov models) were constructed to estimate for each recall interval:

- The total cost of oral health reviews (OHRs) and the cost associated with the treatment of decay (filling deciduous and permanent dentition) per patient
- and number of teeth free from decay, extraction, or fillings for deciduous teeth (dmft) and permanent teeth (DMFT).

Separate models were constructed for a cohort between the ages of one and six and for another cohort between the ages of 12 and 80. Separate analyses were undertaken for different risk subgroups according to socio-economic background (manual versus non-manual) and water fluoridation. For each risk group, the outcome of the model was cost per tooth free from decay, fillings, or extraction at the end of the model simulation.

They found that, as the recall interval decreases, overall costs are increased but there are more DMF-free teeth. The increased effectiveness was highest in non-fluoridated and manual socio-economic classes. As recall intervals moved step by step from 36 months to three months the incremental cost per additional DMF-free tooth gained became greater and greater. Moving from six months to three months intervals was considered to be not cost-effective, however given that the threshold of cost per DMF-free tooth is not known, such a conclusion is largely conjecture. The results were not sensitive to changes in hazard rate and restoration survival rate. However, not all model parameters were tested in the sensitivity analysis – the biggest omission being the clinical effectiveness of dental check-ups, an assumption that was not made explicit in the report. Refer to the original guideline document for a discussion on limitation of the model.

Other Studies

One cost analysis and three resource impact analyses were selected for tabulation (see Table 4 and Table 5 in the original guideline document).

Conclusions

The studies included in this updated review are methodologically and clinically heterogenous, restricting comparisons between studies and limiting generalisability to the United Kingdom (UK) context. All studies were judged to have some threat to validity and a major limitation of a number of studies was the method used to measure the frequency of the intervention. The majority of studies used a subjective measure of dental check frequency, which compromised the validity of the data collected. It is reasonable to assume that attendance frequency is "over-estimated" in questionnaire/interview type surveys and there is some empirical evidence to support this assumption.

Due to the study designs employed it is impossible to determine whether observed differences between comparison groups are due to differences in the frequency of provision of the intervention (dental check) or whether these differences can be attributed to the presence of other known or unknown potential confounding factors not controlled for in the analysis.

Overall, there was no consistency observed across studies in the direction of effect of different dental check frequencies on measures of caries and periodontal disease. There appears to be some weak evidence from three studies that regular attendance is associated with improved quality of life as it pertains to oral health.

Due to the heterogeneity of populations, interventions, comparisons, and outcome measures used in these studies, this finding should be interpreted cautiously.

There were no economic comparisons of dental recall intervals published since the Health Technology Assessment (HTA) report. Those studies that were included in the HTA report were based on specific populations and were not based on rigorously controlled trials. The model that was developed for the HTA report itself was the only study to compare costs and health outcomes for a number of different recall intervals in a UK context but it too had major limitations.

Considered in the context of the HTA Report, the results of this updated review fail to alter the conclusions of the original review:

- There is little evidence to either support or refute the practice of encouraging 6 monthly dental checks in adults or children.
- There is little evidence to suggest an optimal dental check frequency for any of the outcomes considered.
- There remains uncertainty in how patients value their oral health.
- Further primary research is needed in order to assess the relative clinical effectiveness and cost-effectiveness of different frequencies of dental check in terms of impact on caries, periodontal disease, oral cancer, and quality of life.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline was validated through two consultations.

1. The first draft of the guideline (the full guideline, National Institute for Clinical Excellence [NICE] guideline and Quick Reference Guide) were consulted with Stakeholders and comments were considered by the Guideline Development Group (GDG)
2. The final consultation draft of the Full guideline, the NICE guideline and the Information for the Public were submitted to stakeholders for final comments.

The final draft was submitted to the Guideline Review Panel for review prior to publication.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Levels of evidence categories (1++ to 4) and recommendation grades (A-D, GPP) are defined at the end of the "Major Recommendations" field.

Clinical Recommendations

D - The recommended interval between oral health reviews should be determined specifically for each patient and tailored to meet his or her needs, on the basis of an assessment of disease levels and risk of or from dental disease.

GPP - This assessment should integrate the evidence presented in this guideline with the clinical judgement and expertise of the dental team, and should be discussed with the patient.

During an oral health review, the dental team (led by the dentist) should ensure that comprehensive histories are taken, examinations are conducted, and initial preventive advice is given. This will allow the dental team and the patient (and/or his or her parent, guardian, or carer) to discuss, where appropriate:

- **B** - the effects of oral hygiene, diet, fluoride use, tobacco, and alcohol on oral health
- **D** - the risk factors (see the checklist in Appendix G of the original guideline document) that may influence the patient's oral health, and their implications for deciding the appropriate recall interval
- **GPP** - the outcome of previous care episodes and the suitability of previously recommended intervals
- **GPP** - the patient's ability or desire to visit the dentist at the recommended interval
- **GPP** - the financial costs to the patient of having the oral health review and any subsequent treatments.

GPP - The interval before the next oral health review should be chosen, either at the end of an oral health review if no further treatment is indicated, or on completion of a specific treatment journey.

The recommended shortest and longest intervals between oral health reviews are as follows.

- **GPP** - The shortest interval between oral health reviews for all patients should be 3 months.

  A recall interval of less than 3 months is not normally needed for a routine dental recall. A patient may need to be seen more frequently for specific reasons such as disease management, ongoing courses of treatment, emergency dental interventions, or episodes of specialist care, which are outside the scope of an oral health review.

- **GPP** - The longest interval between oral health reviews for patients younger than 18 years should be 12 months.

  There is evidence that the rate of progression of dental caries can be more rapid in children and adolescents than in older people, and it seems to be faster in primary teeth than in permanent teeth (see Section 3.1.2 of the full guideline document). Periodic developmental assessment of the dentition is also required in children.

Recall intervals of no longer than 12 months give the opportunity for delivering and reinforcing preventive advice and for raising awareness of the importance of good oral health. This is particularly important in young children, to lay the foundations for life-long dental health.

- **GPP** - The longest interval between oral health reviews for patients aged 18 years and older should be 24 months.

  Recall intervals for patients ***who have repeatedly demonstrated that they can maintain oral health and who are not considered to be at risk of or from oral disease*** *may be extended over time up to an interval of 24 months. Intervals of longer than 24 months are undesirable because they could diminish the professional relationship between dentist and patient, and people's lifestyles may change.*

GPP - For practical reasons, the patient should be assigned a recall interval of 3, 6, 9, or 12 months if he or she is younger than 18 years old, or 3, 6, 9, 12, 15, 18, 21, or 24 months if he or she is aged 18 years or older.

GPP - The dentist should discuss the recommended recall interval with the patient and record this interval, and the patient's agreement or disagreement with it, in the current record-keeping system.

GPP - The recall interval should be reviewed again at the next oral health review, to learn from the patient's responses to the oral care provided and the health outcomes achieved. This feedback and the findings of the oral health review should be used to adjust the next recall interval chosen. Patients should be informed that their recommended recall interval may vary over time.

Definitions:

Levels of Evidence

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- High-quality meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs with a very low risk of bias

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Recommendation Grades

Recommendation Grades

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- Evidence level 3 or 4, or
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GPP

- A good practice point (GPP) is a recommendation for best practice based on the clinical experience of the Guideline Development Group

CLINICAL ALGORITHM(S)

An algorithm is provided in the original guideline document with a simplified overview of oral health assessment and oral health review

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is provided for each recommendation (see "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Improved or maintained quality of life and reduced morbidity associated with oral and dental disease

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Health professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Local health communities should review their existing practice for dental recall against this guideline. The review should consider the resources required to implement the recommendations set out in the original guideline document, the

people and processes involved, and the timeline over which full implementation is envisaged. It is in the interests of patients that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways, and protocols should be reviewed in the light of this guidance and revised accordingly.

This guidance contains tools and suggestions to facilitate implementation and review (see Appendix G of the original guideline document). These are designed to help National Health Service (NHS) dental practices and their patients get used to what will be for many a new way of planning and receiving routine NHS dental care. A quick reference guide for the dental team and a poster and leaflet for the public are also available (see "Availability of Companion Documents" and "Patient Resources" fields).

NHS Clinical Care Pathways

NHS clinical care pathways are being developed to further the aims outlined in the Department of Health's strategy document *NHS Dentistry: Options for Change* (2002). The first clinical care pathway for NHS dentistry is being developed by the Dental Health Services Research Unit at the University of Dundee and deals with the initial oral health assessment and subsequent oral health reviews (see Appendix A in the original guideline document). It is being tested by NHS Options for Change field sites, which include dental practices, primary care trusts, and strategic health authorities who volunteered to test the modernization proposals outlined in *Options for Change*. The pathway accommodates the National Institute for Clinical Excellence (NICE) recommendations on recall intervals and this should help a seamless move into modernised, preventive NHS dental care.

Patient records should show that appropriate recall intervals have been identified, based on the assessment of risk in discussion with the patient. The following criteria can be used to audit adherence to the guideline recommendations.

- At the end of each oral health review there is a record for each patient of an assessment of disease and disease risk.
- At the end of each oral health review, or at completion of treatment, there is a record for each patient of the recall interval recommended by the dentist for the next oral health review.
- The interval agreed each time, for each patient is:
    - 3, 6, 9, or 12 months for patients younger than 18 years, or
    - 3, 6, 9, 12, 15, 18, 21, or 24 months for patients aged18 years or older.
- Where there is disagreement between the dentist and the patient over the recall interval, the reason for this is recorded.

Further information on local and national audit is available in the full guideline.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Chart Documentation/Checklists/Forms

Clinical Algorithm
Foreign Language Translations
Patient Resources
Quick Reference Guides/Physician Guides
Wall Poster

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Acute Care. Dental recall: recall interval between routine dental examinations. London (UK): National Institute for Clinical Excellence (NICE); 2004 Oct. 118 p. [153 references]

ADAPTATION

Not applicable: the guideline was not adapted from another source.

DATE RELEASED

2004 Oct

GUIDELINE DEVELOPER(S)

National Collaborating Centre for Acute Care - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Clinical Excellence (NICE)

GUIDELINE COMMITTEE

Guideline Development Group

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The Guideline Development Group were asked to declare any possible conflict of interest, and none that could interfere with their work on the guideline was declared.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format [PDF] format from the National Institute for Clinical Excellence (NICE) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- National Collaborating Centre for Acute Care. Dental recall: recall interval between routine dental examinations. London (UK): National Institute for Clinical Excellence (NICE); 2004 Oct. 38 p. (Clinical guideline; no. 19). Available in Portable Document Format (PDF) from the National Institute for Clinical Excellence (NICE) Web site.
- Dental recall: recall interval between routine dental examinations. Quick reference guide. 2004 Oct. 4 p. Available in Portable Document Format (PDF) from the National Institute for Clinical Excellence (NICE) Web site.
- Dental recall. Risk factor checklist. 2004 Oct. 2 p. Electronic version available from the National Institute for Clinical Excellence (NICE) Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N0734. 11 Strand, London, WC2N 5HR.

Additionally, Audit Criteria are available in Section 6 of the original guideline document.

PATIENT RESOURCES

The following are available:

- When should my next dental check-up be? Information for the public. 2004 Oct. 1 p. Available in English and Welsh in Portable Document Format (PDF) from the National Institute for Clinical Excellence (NICE) Web site.
- Dental recall. Poster. 2004 Oct. 1 p. Available in English and Welsh in Portable Document Format (PDF) from the National Institute for Clinical Excellence (NICE) Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N0735. 11 Strand, London, WC2N 5HR.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

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