Dental recall: recall interval between routine dental examinations

NICE guideline

First draft for consultation, February 2004

If you wish to comment on the recommendations, please make your comments on the **full** version of the draft guideline.

Contents

The recommendations in this guideline are designed to assist dentists in using their clinical judgment to assign recall intervals that are appropriate to the needs of individual patients. These recommendations are based on a review of the scientific literature that was considered by the Guideline Development Group in the context of its collective clinical expertise and views on patient preferences.

The following guidance is evidence based. The grading scheme used for the recommendations (A, B, C, D or good practice point [GPP]) is described in Appendix A; a summary of the evidence on which the guidance is based is provided in the full guideline (see Section 5).

1 Guidance

The guidance is divided into two sections (1.1 and 1.2). Section 1.1 contains the clinical recommendations. Section 1.2 discusses how the clinical recommendations can be implemented in practice. A 'checklist' is provided that will assist clinicians in the process of assigning a recall interval for an individual patient. The contents of the checklist and the manner in which it should be used when assessing a patient's risk of or from dental disease are outlined. A graphic 'tool' is then provided which can be used to communicate to both patients and to other members of the dental team the process of selecting, agreeing and reviewing appropriate recall intervals. Lastly, in Appendix B, a series of clinical scenarios are presented to illustrate how recall interval selection will work in practice when the guidance is followed.

1.1 Clinical recommendations

1.1.1 The recommended interval between oral health reviews should be determined specifically for each patient based on disease levels and risk of or from dental disease. **[D]**

1.1.2 During an Oral Health Assessment or Oral Health Review, the dental team (as led by the dentist) should ensure that comprehensive histories are taken, examinations conducted and initial preventive advice is given to allow the dental team and the patient (or parent/guardian of the patient) to discuss, where appropriate:

- the effects of oral hygiene, diet, fluoride use, tobacco and alcohol on oral health. **[B]**
- the risk factors that may potentially impact on a patient's oral health and the implication these will have for deciding the appropriate time interval for their next routine visit **[B]**
- the outcome of previous care episodes and the suitability of previously recommended intervals **[GPP]**
- the patient's ability/desire to visit the dentist at the interval indicated by their individualised risk factors and by the clinical judgment of the dental team **[GPP]**

- the monetary cost to the patient of the Oral Health Assessment or Review and any subsequent treatments. **[GPP]**

1.1.3 The interval before the next Oral Health Review (or Assessment) should be chosen, agreed with the patient and recorded. This choice of interval should be made either at the end of an Oral Health Review (or Assessment) if no further treatment were indicated, or at the completion of a specific treatment journey. **[GPP]**

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

- The shortest interval between oral health reviews for all patients should be 3 months. **[GPP]**
- The longest interval between oral health reviews for people below 18 years of age should be 12 months. **[GPP]**
- The longest interval between oral health reviews for people 18 years old and over should be 24 months. **[GPP]**

1.1.5 The specific recommended interval between routine oral health reviews for an individual patient at a specific point in time should be tailored to meet their needs on the basis of an assessment of disease levels and risk of or from dental disease. This assessment should incorporate the best available scientific evidence, the individual clinical judgement and expertise of dental personnel and should take into consideration the values and expectations of the patient. **[GPP]**

1.1.6 For practical reasons, patients should be assigned (at a particular point in time) a recall interval of 3, 6, 9, or 12 months if they are below 18 years of age, or 3, 6, 12, 18 or 24 months if they are aged 18 years or over. **[GPP]**

1.1.7 The recall interval agreed and assigned 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 should be used to adjust the next recall interval chosen. **[GPP]**

1.2 Selecting the appropriate recall interval for an individual patient

The selection of an appropriate recall interval for an individual patient is a multifaceted clinical decision that is difficult, if not impossible, to evaluate mechanistically. In making that decision, clinicians must integrate their own clinical expertise (the proficiency and judgment they have acquired through clinical experience and clinical practice) with the best available clinically relevant scientific evidence relating to

a patient's oral and general health. This guideline aims to assist clinicians in this decision-making process by:

- advocating that clinicians should carry out a risk assessment for each individual patient
- identifying specific factors that form an integral part of this risk assessment and that should be taken into account when assigning a recall interval for each individual patient.

The risk assessment process and its application to the selection of recall intervals is founded on the premise that the frequency and type of oral health supervision needed by an individual patient depends on the likelihood that specific diseases or conditions may develop. When carrying out a risk assessment for a patient, clinicians should examine the patient for a) risk factors that may have a negative impact on oral health and b) protective factors that may promote oral health. By carrying out a risk assessment for each individual patient every time they attend for an oral health review the dental professional will be better positioned to make specific preventive and treatment recommendations and to assign a recall interval for that patient that is particular to their individual needs.[1]

A number of factors that may modify the choice of recall interval and that feed into the risk assessment process are identified in the form of a 'checklist' presented on the following pages. It should be noted that this checklist is merely intended as a guide to assist the clinician and the dental team when carrying out a risk assessment. It is by no means intended to be an exhaustive list encompassing all of the factors that may influence the choice of a recall interval for an individual patient.

Therefore, although the Guideline Recommendations are firm, we recommend further research to explore the most effective and practical mechanisms for implementing and operationalising the key recommendations contained in this guideline in general dental practice. Any proposed delivery mechanism, such as the checklist outlined overleaf, must be rigorously piloted and evaluated. We have presented this checklist and the accompanying text as a preliminary guide to assist clinicians in assigning recall intervals.

[1] Adapted from http://www.brightfutures.org/oralhealth/pdf/RiskA_67to73.pdf

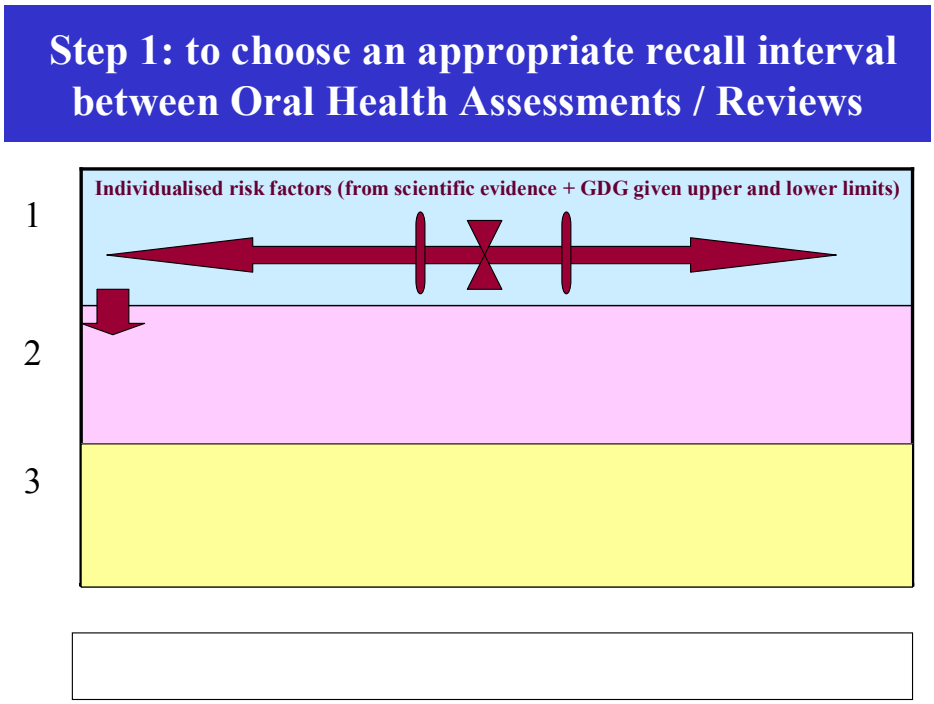
Name: ..... Date of Birth: .....

Oral Health Review Date:						
Medical History	Yes	No	Yes	No	Yes	No
Conditions that potentially put the patient's general health at increased risk if they should develop dental disease/infection (e.g. congenital/acquired cardiovascular disease, bleeding disorders, immunosuppression)	☐	☐	☐	☐	☐	☐
Conditions that increase a patient's risk of developing dental disease (e.g. diabetes, xerostomia, long-term intake of medications containing sugar, epilepsy [phenytoin therapy and gingival overgrowth], acid reflux leading to tooth surface loss)	☐	☐	☐	☐	☐	☐
Conditions that may complicate the provision of dental treatment or may compromise the patient's ability to maintain their oral health (e.g. special needs patients, cleft lip/palate, severe malocclusion, anxious/nervous/phobic patients)	☐	☐	☐	☐	☐	☐
Social History						
High caries in mothers and siblings	☐	☐	☐	☐	☐	☐
Tobacco use	☐	☐	☐	☐	☐	☐
High/excessive alcohol use	☐	☐	☐	☐	☐	☐
Family history of chronic or aggressive (early onset/juvenile) periodontitis	☐	☐	☐	☐	☐	☐
Dietary Habits						
High sugar intake	☐	☐	☐	☐	☐	☐
Exposure to Fluoride						
Use of fluoride toothpaste	☐	☐	☐	☐	☐	☐
Other sources of fluoride eg live in a water fluoridated area	☐	☐	☐	☐	☐	☐
CLINICAL EVIDENCE/DENTAL HISTORY						
Recent and Previous Caries Experience						
New lesions since last check-up	☐	☐	☐	☐	☐	☐
Anterior caries or restorations	☐	☐	☐	☐	☐	☐
Premature extractions due to caries	☐	☐	☐	☐	☐	☐
Past root caries or large number of exposed roots	☐	☐	☐	☐	☐	☐
Heavily restored dentition	☐	☐	☐	☐	☐	☐
Recent and Previous Periodontal Disease Experience						
Previous history of periodontal disease	☐	☐	☐	☐	☐	☐
Evidence of gingivitis	☐	☐	☐	☐	☐	☐
Presence of periodontal pockets (BPE code 3 or 4) and/or bleeding on probing	☐	☐	☐	☐	☐	☐
Presence of furcation involvements or advanced attachment loss (BPE Code *)	☐	☐	☐	☐	☐	☐
Mucosal Lesions						
Mucosal Lesion	☐	☐	☐	☐	☐	☐
Plaque						
Poor level of oral hygiene	☐	☐	☐	☐	☐	☐
Plaque retaining factors	☐	☐	☐	☐	☐	☐
Saliva						
Low saliva flow rate	☐	☐	☐	☐	☐	☐
Erosion and Tooth Surface Loss						
Clinical evidence of tooth wear	☐	☐	☐	☐	☐	☐
Recommended recall interval:		months		months		months

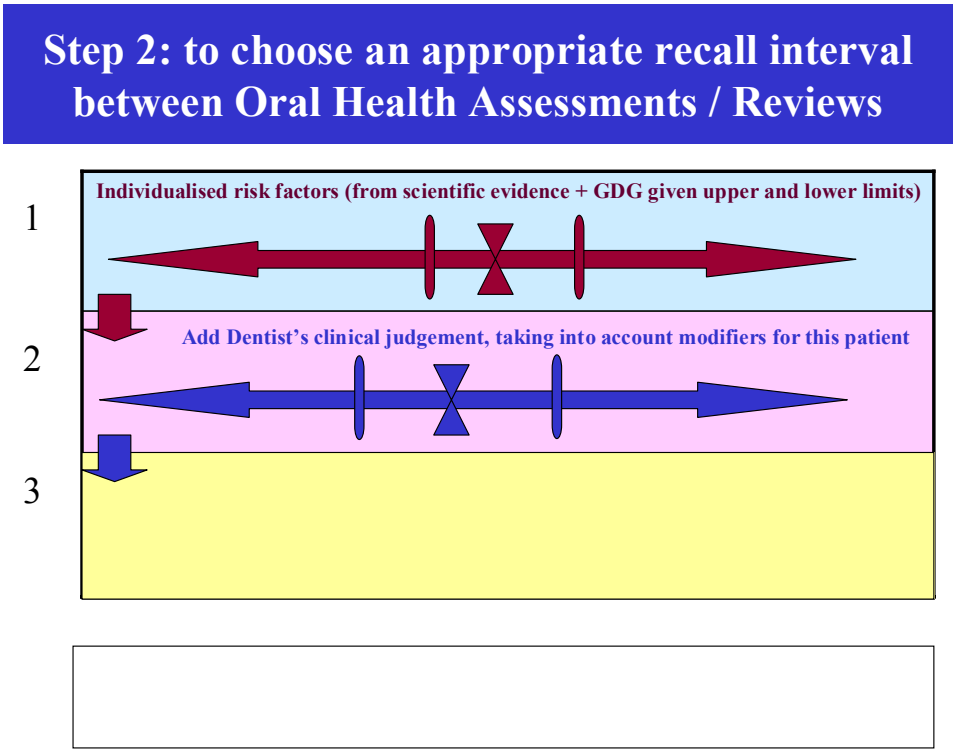
Notes:

1.2.1 **Recall Interval Selection Slider Tool**

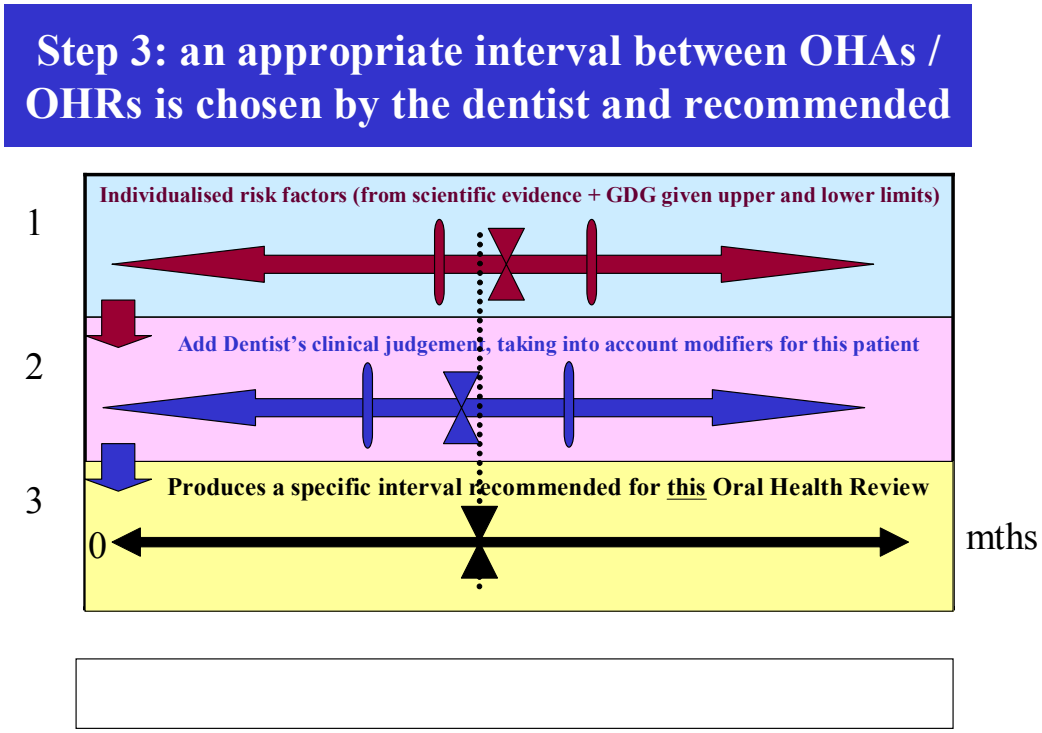
This 'tool' has been designed and developed by the Guideline Development Group in order to be enable dentists to communicate clearly with the patient (and with other members of the dental team) the sequential process used to select an interval appropriate to a particular patient at a particular time. The tool may ultimately be used as a leaflet, poster, model or interactive computer graphic.



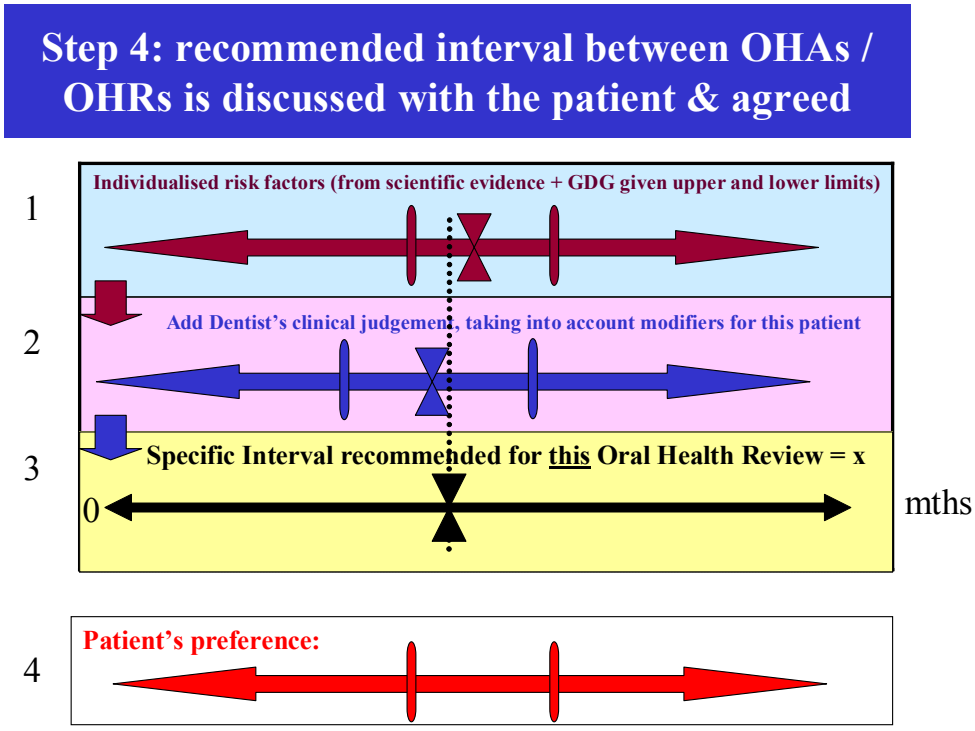
The first step looks generally at the evidence available and, for the specific age of the patient, the upper and lower limits which are stipulated in this guidance.



The second step involves the tailoring of the interval according to the dentist's judgement of all the information available to him/her. This is where the checklist of modifying factors is considered carefully in the context of this patient's histories and examinations.

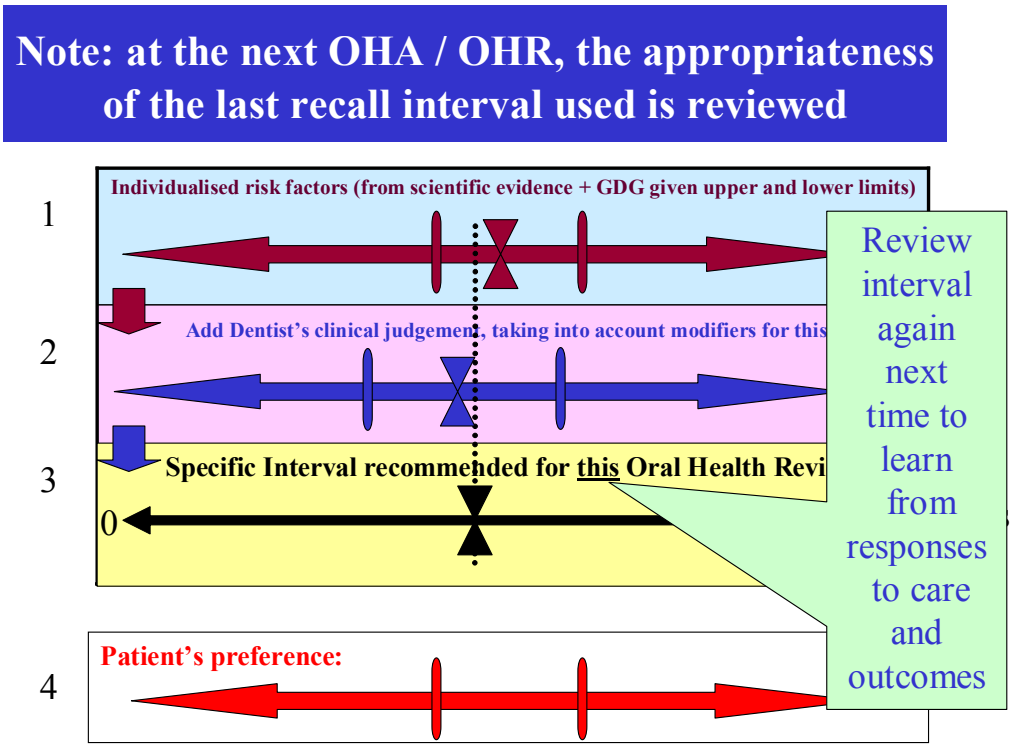


The third step is where the clinician (advised on many occasions by other members of the dental team) integrates all the diagnostic and prognostic information available at this particular time point to make a recommendation of a specific recall interval between now and the next Oral Health Review.



Step four is to discuss the recommended interval with the patient and explore their preferences and expectations. An agreed interval should result and this is then recorded and a recall appointment should then be made.

If for any reason the patient is unable to accept the recommendation, this should also be recorded.



The final step in the chain of recording, developing and sharing knowledge is to review the success, or otherwise, of the chosen interval at the next Oral Health Review. In this way the next interval is adjusted accordingly depending on the patient's ability to maintain oral health between Oral Health Reviews.

It may be that the interval is maintained at the same level if it is achieving its aims. Alternatively, in a patient with low disease activity, it will be possible to gradually extend the interval out towards the 24-month maximum period – once the patient and the dental team are confident that this is satisfactory. A third alternative is for patients whose disease activity continues unabated in spite of attempts at preventive care – they may need the interval to be shortened and for more intensive preventive care to be supervised more closely.

2 Notes on the scope of the guidance

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development of this guideline, following a period of consultation; it is available from http://www.nice.org.uk/Docref.asp?d=84419

The recommendations contained in this guideline are intended to assist clinicians in selecting recall intervals between Oral Health Reviews (OHRs) that are appropriate to the needs of individual patients. The guideline includes recommendations for the optimal recall frequency for routine dental checks for patients of all ages (both dentate and edentulous patients) and covers primary care received from NHS dental staff (dentists, independent contractors contracting within the NHS, dental hygienists and therapists) practicing in England and Wales. The guideline takes into account the potential of the patient and the dental team to improve or maintain the quality of life and to reduce morbidity associated with oral and dental disease.

In arriving at recommendations, the impact of dental checks on patients' well-being, general health and preventive habits; caries incidence and avoiding restorations; periodontal health and avoiding tooth loss; and avoiding pain and anxiety have been considered.

The guideline **does not** cover:

- intervals between dental examinations that are not routine dental recalls; that is, intervals between examinations related to ongoing courses of treatment, or part of current dental interventions.
- emergency dental interventions, or intervals between episodes of specialist care.
- the prescription and timing of dental radiographs. Guidance on selection criteria for dental radiographs has been developed in

the UK by the Faculty of General Dental Practitioners (FGDP1998) and is currently being updated.

- recall intervals for routine scale and polish treatments. A systematic review of this area is currently being conducted by the Cochrane Oral Health Group (COHG).

3 Implementation in the NHS

3.1 In general

Local health communities should review their existing practice for dental recall against this guideline as they develop their Local Delivery Plans. The review should consider the resources required to implement the recommendations set out in Section 1, 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 a number of tools and suggestions to facilitate effective implementation and review. The provision of a comprehensive Risk Checklist, with explanatory notes for how best to operationalise it, combined with the Recall Interval Selection Slider Tool to help communication and discussion with patients and the Clinical Scenarios to provide a range of worked clinical examples are all designed to help 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.

NHS Clinical Care Pathways

The first Clinical Care Pathway to be developed is one that deals with the Oral Health Assessment and the Oral Health Review. This Pathway is currently under development and will be tested by NHS Options for Change Field Sites. The Pathway has been designed from the inception to accommodate the

NICE recommendations on recall intervals and this integration should help a seamless introduction into the modernised, preventive NHS dental care.

Support for Practices, Dental Teams and for Patients

The Guideline Document, Quick Reference Guide, Leaflets and the Patient version of the guidance should all ensure that easy to access information about the recall recommendations are widely available to dental practices and clinics delivering NHS care in England and Wales.

Postgraduate and Continuing Education

It is hoped that the key messages of the guidance and the clinical, preventive philosophy behind it can be incorporated in planned educational activities over the coming year.

NeLH, the virtual Centre for Improving Oral Health and the developing National Oral Health Knowledge Service

A number of developments in supporting and coordinating Evidence Based Dentistry are currently under development. Steps will be taken to ensure that the guidance appears on the National electronic Library for Health (NeLH) and that its rationale and recommendations are promoted by the virtual Centre for Improving Oral Health and are linked to new dental IT developments.

3.2 Audit

Suggested audit criteria are listed in Appendix D. These can be used as the basis for local clinical audit, at the discretion of those in practice.

Given that these recommendations will represent a significant departure from current practice for many dentists, the Guideline Development Group specifically recommends the following.

3.2.1 The acceptability and performance of the guidance should be assessed routinely in order to refine and improve the guidance informing the recommended interval and the effectiveness of the Oral Health Assessment/Oral Health Review.

This means that as the new arrangements for delivering dental care come in and settle down, an impact assessment of the introduction of this guidance should be introduced. It is hoped that arrangements can be made to establish what changes in recall behaviour are brought about by the publication of this guidance, although the simultaneous introduction of a number of changes may complicate this.

3.2.2 A new minimum dataset should be established, consistent with the new, more preventive, philosophy of the Options for Change style evolving arrangements for NHS Dentistry. Data should be recorded routinely in such a way to facilitate its use for service improvement at the patient, practice, primary care trusts, Shadow Health Authority and national levels.

- **Minimum Data requirements** – it will be important for the profession, the PCTs and the Shadow Special Health Authority (Dental Practice Board) to agree a coherent and workable dataset to allow efficient collection of data and the comparison of what happens in different localities over time.

- **Audit at the Practice level** – recall intervals will make a ready and important audit topic at the practice level. Some coordinated production of audit tools may facilitate this process. The incorporation of the minimum data set into Dental IT software would help automate the data collection and reduce the administrative burden. It is important that any patient who may suffer from disease progression and is allocated a more extended recall should be monitored.

- **Audit at the local (PCT) level** – this will become more important as PCTs develop the local arrangements and seek to understand the quality dimensions and patient acceptability of the new styles of dental care. The Strategic Health Authorities (SHAs) may also call for the (anonymised) results of such local audits.

- **Audit at local National level** – with the radical changes in commissioning NHS dental care, there will be a need to understand how the new arrangements are working and to evaluate the overall performance to the new systems and the quality of care being delivered. Once again, this will demand more of the new IT arrangements which hold the key to ready and efficient access to understanding change and quality.

- **New Dental and NHS-wide IT** developments should, over time, allow much of this routine information to be collected without additional administrative burdens. It is essential that these needs are reflected in the design, specification and development of new IT systems and that these requirements are met while satisfying contemporary data protection and privacy requirements.

If not addressed early on, there is a danger that the automated collection and processing of audit data about dental recalls, which will be needed, may be compromised. This is due to the scale and pace of the remuneration changes which will be introduced in 2005. Confidentiality considerations are a further complication as appropriate information and agreement must be obtained from the patient to ensure that the legitimate use of patient information for improving the quality of patient care can continue.

4 Research recommendations

The following research recommendations have been identified for this NICE guideline, not as the most important research recommendations, but as those

that are most representative of the full range of recommendations. The Guideline Development Group's full set of research recommendations is detailed in the full guideline produced by the National Collaborating Centre for Acute Care (see Section 5).

- Dental attendance patterns should be examined for changes following the publication of the guideline. This requires that the future use of routine data for this purpose must be communicated appropriately to patients in order to satisfy confidentiality considerations.
- Following publication of the guideline, information will be needed on whether patients visit the dentist at the interval deemed appropriate, and the reasons why or why not.
- High-quality research is needed on the long-term clinical and cost effectiveness of one-to-one oral health advice and whether this may depend upon:
  - the frequency with which it is delivered
  - characteristics of the individual patient other than their physical or oral health (for example, age, sex, social class, occupation)
  - the medium used to deliver the advice
  - the physical and/or oral health of the patient
  - who is imparting or delivering the advice.

- High-quality research is needed to examine the effects of varying dental recall intervals on oral health. More specifically, a better understanding is required of what aspect or aspects of the oral health review impact on oral health.
- High-quality research is required to examine the impact of oral health (relating to gingivitis, caries, periodontal disease, and mucosal disease) on quality of life.
- High-quality research is needed to examine the effects on periodontal health of a routine scale and polish treatment in different populations. Specifically, research is needed to

examine the clinical effectiveness and cost effectiveness of providing this treatment at different time intervals.

5 Full guideline

The National Institute for Clinical Excellence commissioned the development of this guidance from the National Collaborating Centre for Acute Care. The Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The full guideline, *Dental recall: recall interval between routing dental examinations*, is published by the National Collaborating Centre for Acute Care; it is available on its website (http://www.rcseng.ac.uk/about_the_college/role_of_the_college/nccac_html) and can be ordered at cost, the NICE website (www.nice.org.uk) and on the website of the National electronic Library for Health (www.nelh.nhs.uk). **[Note: these details will apply to the published full guideline.]**

The members of the Guideline Development Group are listed in Appendix C. Information about the independent Guideline Review Panel is given in Appendix D.

The booklet *The Guideline Development Process – Information for the Public and the NHS* has more information about the Institute's guideline development process. It is available from the Institute's website and copies can also be ordered by telephoning 0870 1555 455 (quote reference N0038).

6 Related NICE guidance

There is no related NICE guidance.

7 Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

A version of this guideline for [insert target group(s) as in IFP] is available from the NICE website (www.nice.org.uk) or from NHS Response Line (telephone 0870 1555 455 and quote reference number N0XXX for an English version and N0XXX for a version in English and Welsh).

Appendix A: Grading scheme

The grading scheme and hierarchy of evidence used in this guideline (see Table) is from Eccles and Mason (2001).

Recommendation grade	Evidence
A:	directly based on category I evidence
B:	directly based on: • category II evidence, **or** • extrapolated recommendation from category I evidence
C:	directly based on: • category III evidence, **or** • extrapolated recommendation from category I or II evidence
D:	directly based on: • category IV evidence, **or** • extrapolated recommendation from category I, II, or III evidence

Evidence category	Source
I:	evidence from: • meta-analysis of randomised controlled trials, **or** • at least one randomised controlled trial
II:	evidence from: • at least one controlled study without randomisation, **or** • at least one other type of quasi-

	experimental study
III:	evidence from non-experimental descriptive studies, such as comparative studies, correlation studies and case–control studies
IV:	evidence from expert committee reports or opinions and/or clinical experience of respected authorities

Adapted from Eccles M, Mason J (2001) How to develop cost-conscious guidelines. *Health Technology Assessment* 5:16.

Appendix B: Clinical scenarios

SCENARIO A

Age: Patient A is 4 years old
Attendance record: Patient A is attending your practice for the first time (for an Oral Health Assessment).
Medical history: Patient A has no medical history of note.
Social history: Patient A has two older siblings aged 7 and 10 years, who have been patients of yours for the last 2 years. Both older siblings have no decayed, missing or filled teeth and have good oral hygiene.
Dietary habits: Patient A has apparently healthy dietary habits which suggest no specific factors likely to increase risk of caries developing.
Use of fluoride: Patient A brushes with fluoride toothpaste regularly twice daily
Clinical evidence/dental history: No previous history of dental caries and no other factors which may increase caries risk.
Plaque: Oral hygiene is good with only minimal plaque deposits.
Saliva: No specific factors which may lead to reduced salivary flow
Other:

Recall Interval recommended by clinician for oral health review:
6 months

Rationale: The history taking and clinical examination for this patient reveal no medical or social history of note, the patient has no cavities and has good oral hygiene and dietary practices. However, although there are no obvious risk factors, as this is a 'new patient' with no established dental history, you feel it is prudent to assign a conservative recall interval of 6 months initially.

SCENARIO B

Age: Patient B is 3 years old.
Attendance record: Patient B has attended twice before, although this visit is the first time at this practice.
Medical history: Patient B has no medical history of note.
Social history: The father of Patient B is a smoker.
Dietary habits: Discussions with the mother suggests that the patient's sweet consumption is relatively low, although the review of parents' consumption at their OHA found quite a high consumption with sugar being used in tea and coffee.
Use of fluoride: Parents use a major brand of toothpaste which patient Y also uses, although the mother says she doesn't like the taste too much.
Clinical Evidence and dental history: All primary teeth are present and there are no signs of any clinical lesions.
Plaque: Small amounts visible on the buccal sulcus around the Ds and Es.
Saliva: Nothing abnormal detected.
Other: Both parents have a DMF of above 10 although the commented that they have improved their oral hygiene habits following discussions with their previous dentist. They have not had any new fillings for the past 3 years.

Recall Interval recommended by clinician for oral health review:
6 months

Rationale

While no clinical lesions have been detected, on balance, the modifying factors are slightly negative. Oral hygiene is not particularly good, and the child is probably not using too much toothpaste as 'she doesn't like the taste'. Oral hygiene instruction and dietary advice is being offered (to parent and child) as part of the treatment being proposed following the present visit. Should there be no lesions present and OHI has improved at the next visit, then it may be possible to extend the recall interval.

SCENARIO C

Age: Patient C is 11.5 years old

Attendance record: Patient C is attending your practice for the first time (for an Oral Health Assessment).
Medical history: Patient C has no medical history of note.
Social history: Patient C has two older siblings aged 13 and 15 years, who have been patients of yours for the last 2 years. Both older siblings have had decay in the primary and permanent dentition. The patient's mother also has a high DMF.
Dietary habits: Patient drinks carbonated drinks at least 3 times per day
Use of fluoride: Irregular brushing and resident in an area with sub-optimal levels of fluoride in the water supply.
Clinical evidence/dental history: Three restorations present in primary teeth and there is one carious lesion requiring restoration. There is gingival inflammation in all areas.
Plaque: Oral hygiene is poor.
Saliva: No specific factors which may lead to reduced salivary flow.
Other: None

Recall Interval recommended by clinician for oral health review:
3 months

Rationale: The presence of a large number of additional risk modifiers (including that this is the patient's first visit to the practice) indicates that a short review interval would be prudent, hence 3 months.

SUBSEQUENT HISTORY: After pro-active prevention, patient's compliance is good, drastically reducing in-between meals drinking of carbonated drinks, improving oral hygiene and using a high-fluoride toothpaste regularly twice daily. Over subsequent visits, no new caries is seen and the recall interval is extended to 6 months.

SCENARIO D

Age: Patient D is 14 years old
Attendance record: Patient D has been attending your practice for regular reviews since 5 years of age.
Medical history: Patient D has no medical history of note.
Social history: Patient D has one younger sibling aged 11 who is caries free. The patient's mother is also caries free.
Dietary habits: Patient D has dietary habits which suggest no specific factors likely to increase risk of caries developing.
Use of fluoride: Brushing with fluoride toothpaste regularly twice daily.
Clinical evidence/dental history: No previous history of dental caries and no other factors which may increase caries risk. The gingivae are healthy.
Plaque: Oral hygiene is good with only minimal plaque deposits.
Saliva: No specific factors which may lead to reduced salivary flow.
Other:

Recall Interval recommended by clinician for oral health review:
12 months

Rationale: Long-standing patient in permanent dentition with known past history. No past history or current evidence of dental disease and medical history clear. No additional modifiers. Hence considered to be at low risk and review interval of 12 months seems reasonable.
SUBSEQUENT HISTORY: Patient develops new caries in two premolars at 15 years of age. It becomes apparent that a habit of frequently "grazing" between meals has become established and the dentist also records that OH has deteriorated. The patients recall interval is reduced to 6 months. After intensive prevention, the lapses in dietary practices and oral hygiene are reversed and no new caries is subsequently seen.

SCENARIO E

Age: Patient E is a 35-year-old female
Attendance Record: Patient has been attending your practice regularly for six years.
Medical History: Patient has no medical history of note.
Social History: Patient does not smoke and drinks alcohol occasionally at the weekends.

Dietary habits: Patient has a healthy diet with plenty of fresh fruit and vegetables and rarely consumes sugar containing foods and drinks.
Use of Fluoride: Patient brushes twice a day with a fluoride-containing toothpaste.
Clinical Evidence and dental history: Patient has no missing teeth and five occlusal amalgam fillings present, all in permanent molar teeth. These fillings were placed 15 years ago and have not needed replacement over this period. All fillings are still in excellent condition. Bitewing radiographs taken 12 months ago revealed no interproximal lesions. On examination, her periodontal health is excellent (Basic Periodontal Examination code 0 all quadrants) and she has not needed oral hygiene advice for over three years.
Plaque: Patient brushes twice a day and uses dental floss once a day.
Saliva: Patient has a normal salivary flow rate.
Other: N/A

Recall Interval recommended by clinician for oral health review:
24 months

Rationale for 24 month interval: Over a 6-year period at your dental practice, this patient has not required any restorative intervention. The patient has not had any new carious lesions over a 15 year period and has excellent oral hygiene and dietary habits. The patient's periodontal health is also excellent. The patient's dental status appears stable at this point in time, suggesting that a recall interval of 24 months is appropriate for this patient. However, you inform the patient that they should reattend before this time if there is any change in their medical history, dietary habits, oral hygiene practices *etc* that may impact on their oral health, or if they experience any signs or symptoms of oral disease.

SCENARIO F

Age: Patient F is a 43-year-old female
Attendance Record: Patient has been attending your practice for 9 years and you have reviewed her oral health every 6 months for the first 6 years and on an annual basis for the last 3 years.
Medical History: Patient has no medical history of note.
Social History: Patient does not smoke and drinks alcohol occasionally.
Dietary habits: Patient has a healthy diet with plenty of fresh fruit and vegetables and rarely consumes sugar containing foods and drinks.
Use of Fluoride: Patient brushes three times a day with a fluoride-containing toothpaste.
Clinical Evidence and dental history: Patient has a few small restorations, but has needed no restorative treatment in the last seven years. Bitewing radiographs reveal no approximal lesions and good alveolar bone support. The patients periodontal health is excellent and there is no evidence of gingivitis (Basic Periodontal Examination code 0 all quadrants).
Plaque: Patient A2 brushes three times a day and uses dental floss once a day. On examination, there are no plaque deposits.
Saliva: Patient has a normal salivary flow rate.

Other: N/A

Recall Interval recommended by clinician for oral health review:
24 months

Rationale for 24 month interval: The patient has been attending your practice regularly for nine years. The patient has not required any restorative treatment for seven years. You have progressively increased the recall interval from an original interval of 6 months to 12 months. The patient has been on the latter recall interval for 3 years and you feel confident that the patient's oral health is sufficiently stable to justify a 24-month interval before their next oral health review. However, you inform the patient that they should re-attend before this time if there is any change in their medical history, dietary habits, oral hygiene practices *etc* that may impact on their oral health, or if they experience any signs or symptoms of oral disease.

SCENARIO G

Age: Patient G is a 23 year old female
Attendance Record: Patient has been attending your practice regularly since she was a child.
Medical History: Patient has no medical history of note.
Social History: Patient does not smoke and is a moderate drinker.
Dietary habits: Patient has a healthy diet and rarely consumes confectionary.
Use of Fluoride: Patient brushes 3 times a day with a fluoride containing toothpaste.

Clinical Evidence and dental history: Patient has never required restorative intervention and her periodontal health is excellent (Basic Periodontal Examination code 0 all quadrants).
Plaque: The patient's oral hygiene is excellent and they brush 3 times a day and use dental floss once a day.
Saliva: Patient has a normal salivary flow rate.
Other: N/A

Recall Interval recommended by the clinician for oral health review:
18 months

Rationale: Given the patient's long-established dental history of no restorations and excellent oral hygiene, a recall interval of 24 months might be appropriate. However, recognising that at the patients age, lifestyles can change suddenly and dramatically, you decide to be cautious and recall her in 18 months.

SCENARIO H (*Altering the recall interval from 24 months to 6 months*)

Age: Patient H is a 20-year-old male
Attendance Record: Patient has been attending your practice every 12 months for the last 5 years.
Medical History: Patient has no medical history of note.
Social History: Patient does not smoke and drinks alcohol occasionally at the weekends.
Dietary habits: Patient reports a low frequency of intake of sugar-containing foods and drinks.
Use of Fluoride: Patient brushes twice a day with a fluoride-containing toothpaste.
Clinical Evidence and dental history: Patient has two occlusal amalgam fillings present, all in permanent molar teeth, that were placed 8 years ago. All fillings are still in excellent condition. Bitewing radiographs taken 12 months ago revealed no signs of interproximal lesions.
Plaque: Patient C brushes twice a day and uses dental floss once a day. The patients oral hygiene is excellent and he has not needed oral hygiene instruction or any debridement for three years.
Saliva: Patient C has a normal salivary flow rate.
Other: N/A

Recall Interval recommended by clinician for oral health review:
24 months

Rationale: Over a 5-year period at your dental practice, this patient has not required any restorative intervention. The patient's past caries experience is minimal and he has not had any new carious lesions over an 8-year period and has good oral hygiene and dietary practices. The patient's periodontal health is also excellent. The patient's dental status is judged to be stable at this point in time, suggesting that a recall interval of 24 months is appropriate for this patient. However, you inform the patient that they should reattend before this time if there is any change in their medical history, dietary practices etc that may impact on their oral health, or if they experience any signs or symptoms of dental disease.

24 months later: Patient H returns for an oral health review. The patient has been living away from home for the last 18 months, having just started college.

Attendance Record: At the last oral health review, the patient was advised to re-attend in 24 months. Prior to this, the patient had been attending your practice every 12 months for the last 5 years.
Medical History: Patient has no medical history of note.
Social History: Patient does not smoke but drinks alcohol occasionally at the weekends.
Dietary habits: Patient reports a change in dietary practices over the last 18 months. He consumes a lot of carbonated soft drinks and 'junk food'.
Use of Fluoride: Patient's normal brushing routine has not been followed over last 18 months and use of fluoride toothpaste is less frequent than previously reported.
Clinical Evidence and dental history: Patient has developed one new carious lesion (requiring restorative intervention) on the occlusal surface of one molar tooth. Bitewing radiographs reveal one interproximal lesion. Two 'white spot' lesions are present on the buccal surfaces of two molar teeth. There is evidence of gingivitis in all four quadrants with calculus deposits on the lingual surfaces of the lower anterior teeth (BPE codes 1-2).
Plaque: Patient's oral hygiene has deteriorated over the last 18 months and he has used floss only occasionally.
Saliva: Patient has a normal salivary flow rate.
Other: N/A

Recall Interval recommended by clinician for oral health review:

6 months

Rationale: The patient's risk status has clearly changed since his last oral health review. The patient's altered social environment and the resultant changes in dietary and oral hygiene practices have adversely impacted on his oral health. The patient subsequently undergoes a course of treatment involving restoration of the carious lesions, oral hygiene instruction debridement of all plaque and calculus, dietary advice, and the application of topical fluoride to white spot lesions. In light of the patients recent caries experience and altered diet and oral hygiene, they are recalled for an oral health review in 6 months to reinforce preventive advice and monitor status of white spot lesions. The reason for the short recall interval is explained to the patient and they are informed that it may be possible to extend this interval in the future if dietary habits and oral hygiene improve.

SCENARIO I
Age: Patient I is a 45-year-old male
Attendance Record: Patient has been attending your practice every 6 months for five years.
Medical History: Patient has no medical history of note.
Social History: Patient does not smoke and is a moderate drinker.
Dietary habits: Patient has a healthy, balanced diet and, following dietary advice given at previous oral health reviews, confines intake of sugar-containing foods and drinks to mealtimes with no between meal snacking.
Use of Fluoride: Patient brushes twice a day with a fluoride-containing toothpaste.

Clinical Evidence and dental history: Patient required considerable restorative work when he first attended 3 years ago and his oral hygiene at that time was poor. However, he has not experienced any new carious lesions since then, nor has any of his restorative work needed further attention. The patient's oral hygiene has improved significantly. Bitewing radiographs reveal no approximal lesions and good alveolar bone support.
'The BPE demonstrates gingival bleeding in two sextants but no pocketing or attachment loss (BPE code 1)
Plaque: Patient brushes twice a day and uses dental floss occasionally. The patients oral hygiene is satisfactory, although there are plaque deposits around the cervical margins of the upper and lower molar teeth.
Saliva: Patient has a normal salivary flow rate.
Other: N/A

Recall Interval recommended by clinician for oral health review:
12 months

Rationale: Over a 3-year period at your dental practice, this patient has not required any further restorative intervention after their initial course of treatment. The patient has shown good compliance with dietary and oral hygiene advice given, although the patient should be helped to improve their oral hygiene around the molar teeth. The patient's dental status appears stable and after further advice in oral hygiene and the debridement of plaque deposits and you recommend that the patient attends for an oral health review in 12 months. You do not think it is advisable to increase the interval beyond 12 months as you feel it may be necessary to review oral hygiene at this time.

ADULTS: SCENARIO J

Age: Patient J is a 21-year-old female
Attendance Record: Patient has been attending your practice regularly for 6 years.
Medical History: Patient has no medical history of note and, apart from the contraceptive pill, is taking no medication.
Social History: Patient does not smoke and is a moderate drinker.
Dietary habits: Patient has one can of carbonated soft drink a day and says that she consumes one bar of chocolate a day.
Use of Fluoride: Patient brushes twice a day with a fluoride-containing toothpaste.
Clinical Evidence and dental history: Patient has no decayed, missing or filled teeth and bitewing radiographs reveal no approximal lesions and good alveolar bone support. The BPE demonstrates gingival bleeding, but no pocketing (BPE code 1) in five sextants with calculus present around the lower anterior teeth (BPE code 2).
Plaque: Patient brushes twice a day but does not use dental floss. The patient's oral hygiene is unsatisfactory.
Saliva: Patient has a normal salivary flow rate.
Other: N/A

Treatment plan: The patient requires oral hygiene advice and professional debridement of plaque and calculus.
Recall Interval recommended by the clinician for oral health review:
12 months. Clinician recommends review of oral hygiene with debridement if needed in 6 months.

Rationale: In view of the patient's oral hygiene and periodontal status you recommend a review of oral hygiene with debridement if needed in 6 months. Although the patient has a number of risk factors for dental caries, she has not required restorative intervention and you consider a recall interval of 12 months to be appropriate for the next Oral Health Review.

ADULTS: SCENARIO K

Age: Patient K is a 67-year-old female.
Attendance Record: Patient had full upper and lower dentures fitted by you 2 years ago. She subsequently attended on two occasions for easing of the lower denture.
Medical History: Patient has no medical history of note and is taking no medication.
Social History: Patient does not smoke and does not drink.
Dietary habits: Patient has a healthy diet (lots of fresh fruit and vegetables).
Use of Fluoride: -
Clinical Evidence and dental history: Patient has a healthy oral mucosa with no evidence of any mucosal lesions. Both upper and lower dentures fit and function well.
Plaque: Patients dentures are free of plaque deposits. Patient F rinses her dentures immediately after meals and soaks them in a cleansing solution overnight.
Saliva: Patient has a normal salivary flow rate.
Other: N/A

Recall Interval recommended by clinician for oral health review:
24 months

Rationale: This edentulous patient has been fitted with satisfactory dentures and subsequent follow up has been uneventful. The patients healthy oral mucosa and the patient's established regime for cleansing her dentures influence your decision to recall the patient in 24 months. The patient is advised to reattend if she has any problems with her dentures of if she notices any change in the oral mucosa.

SCENARIO L

Age: Patient L is a 69-year-old male.
Attendance Record: Patient is partially dentate and has been a regular attender at your practice for the last five years.
Medical History: Patient is taking a diuretic and a beta-blocker for blood pressure.
Social History: Patient is a heavy smoker and you suspect he may be a heavy drinker.
Dietary habits:
Use of Fluoride: Patient brushes twice a day with a fluoride toothpaste.
Clinical Evidence and dental history: Patient has white patches in his mouth which have been biopsied by a specialist and found to be non-malignant keratotic lesions associated with his tobacco habit. He has had no new carious lesions in the last 5 years. The patient has a number of areas with moderate pockets of 4-6mm (BPE code 3) and/or some sextants with furcation involvements or attachment loss of 7mm or more (BPE code *).
Plaque: Patients oral hygiene is poor and he does not use interproximal aids such as interdental brushes or floss.
Saliva: Patient has a normal salivary flow rate.
Other: N/A

Recall Interval recommended by clinician for oral health review:
6 months. Arrangements are made for the patient to have periodontal care with the hygienist.

Rationale: The patient has risk factors for oral cancer (mucosal lesions, heavy tobacco use and alcohol consumption). The 'white patches' have been biopsied and found to be non-malignant and the patient has been referred back to you for continuing care and review. However, it is the patient's periodontal status, rather than his risk factors for oral cancer, that is the main determinant of your choice of recall interval. The patient's oral mucosa will be checked as part of the next oral health review in 6 months.

SCENARIO M

Age: Patient M is a 55-year-old male.
Attendance Record: Patient M has been attending your practice for one year.
Medical History: Patient has no medical history of note.
Social History: Patient smokes 35 cigarettes a day and has daily alcohol.
Dietary Habits: Patient has a normal diet.
Use of fluoride: Patient uses fluoride toothpaste.
Clinical Evidence / Dental History: Patient is partially dentate with an upper partial denture. The dentition is sound. There is no obvious mucosal disease.
Plaque: The patient's oral hygiene is good.
Saliva: Salivary flow is normal.
Other: He has tried to give up smoking in the past but without success.

Recall Interval recommended by clinician for oral health review:
6 months

Rationale: Patient has two recognised factors associated with oral cancer and would therefore benefit from regular review of the oral mucosa.

SCENARIO N

Age: Patient N is a 65-year-old male.
Attendance Record: Patient N has been attending your practice for five years.
Medical History: Patient is asthmatic and use a steroid inhaler.
Social History: Patient is non-smoker and has occasional alcohol.
Dietary Habits: Patient has a normal diet.
Use of fluoride: Patient uses fluoride toothpaste.
Clinical Evidence / Dental History: Patient is edentulous and has full dentures that are three years old. There is a white patch on the right lateral margin of the tongue that has been assessed by biopsy in a specialist unit some five years previously and reported as a non-dysplastic leukoplakia. The patient had been discharged back to the practice for on-going care.
Plaque: The patient maintains good denture hygiene.
Saliva: Salivary flow is normal.
Other: The patient has suffered from recurrent candidal infections associated with his inhaler therapy.

Recall Interval recommended by clinician for oral health review:
6 months

Rationale: The patient has a recognised pre-cancerous condition at a high risk site in the mouth. Regular review of the mucosa at 6-monthly intervals would increase the likelihood of early detection of malignant change if this occurred.

SCENARIO O

Age: Patient O is a 48-year-old female
Attendance Record: The patient has been attending your practice regularly for regular periodontal care for 7 years.
Medical History: The patient is taking HRT but otherwise is clear.
Social History: The patient quit smoking 9 years ago and takes on average seven units of alcohol per week.
Dietary habits: Good balanced diet
Use of Fluoride: The patient brushes twice a day with a fluoride-containing toothpaste.
Clinical evidence and dental history: The teeth are moderately heavily restored but restoration margins are accessible and intact. Although there used to be moderately deep pockets on most teeth (BPE code 3), only three 5mm pockets remained following non-surgical periodontal therapy, which was completed 5 years ago. These have remained unchanged since. Gingival health is otherwise excellent.

Plaque: The patient brushes twice a day with and uses interdental brushes every day. There are minimal plaque deposits
Saliva: The patient has a normal salivary flow rate.
Other: N/A

Treatment plan: The patient should continue on three monthly supportive periodontal maintenance visits. The next oral health review should be in 12 months time.

Recall Interval recommended by the clinician for oral health review:
12 months

Rationale: The previous history of periodontitis highlights the need for continuing supportive therapy every three months. In view of the stability of the disease, the next oral health review should be in 12 months time.

SCENARIO P

Age: Patient P is a 56-year-old male
Attendance Record: The patient attended your practice six months ago for the first time and has been compliant in completing a course of non-surgical periodontal therapy
Medical History: The patient is taking low dose aspirin due to family history of coronary heart disease
Social History: The patient is a non-smoker with a moderate alcohol intake of 14 units per week.
Dietary habits: Mix of rushed meals during the week and a reasonably balanced diet at weekends
Use of fluoride: The patient brushes twice a day with a fluoride-containing tooth-whitening toothpaste.
Clinical evidence and dental history: The teeth are heavily restored with a mix of large amalgam restorations and a few crowns. Although there used to be some moderately deep pockets (BPE code 3) in most sextants, only four 5 mm pockets remain without bleeding on probing following non-surgical periodontal therapy. Gingival health is otherwise excellent.
Plaque: The patient brushes twice a day with and uses interdental brushes two to three times per week. The plaque score is reasonably low (25%) and is mainly limited to lingual or palatal molar surfaces,
Saliva: The patient has a normal salivary flow rate.
Other: N/A

Treatment plan: The patient receives advice in home care plaque control at the same visit. He also enters supportive maintenance on a 3-monthly recall.

Recall Interval recommended by the clinician for oral health review:
3 months

Rationale: The response to periodontal therapy is good, although plaque control is not adequate. Since we have no measure of periodontal stability, his periodontal status should be re-examined in 3 months.

Note, if gingival or periodontal disease was still present at this point, the patient should enter a further course of active treatment and would therefore not be subject to a routine recall interval.

At the 3 months recall examination, the periodontal health appears stable. Although the supportive periodontal maintenance should continue every 3 months, the recall for an oral health review could be extended to an interval of between 6 to 12 months depending on the clinician's assessment of risk of breakdown.

SCENARIO Q

Age: Patient Q is a 62-year-old female
Attendance Record: This patient has visited your practice for the last 10 years. Attendance is reasonably good although intervals between examinations have occasionally been prolonged. She is on a supportive periodontal maintenance programme of visits every 3 months.
Medical History: The patient is taking antidepressants.
Social History: The patient is a heavy smoker (self-reported 20-25 cigarettes per day) with an alcohol intake from 2-10 units per week.
Dietary habits: Reasonably balanced diet.
Use of fluoride: The patient brushes twice a day with a fluoride-containing toothpaste for sensitive teeth.
Clinical evidence and dental history: Initially, deep pockets were present in all sextants (BPE 4 or 4*), although not all teeth were affected. Home-care plaque control advice and non-surgical therapy produced substantial improvements. Residual deep pockets remained despite further non-surgical attempts to reduce them. The patient declined referral and preferred extraction when teeth/pockets became problematic. Some teeth have been replaced with an upper removable partial denture.

Plaque: The patient brushes twice a day with and uses wood sticks daily and a single-tufted brush. The plaque score is not consistent but varies from a low level (12%) to levels associated with inflammation (40%). Today it is 30%.
Saliva: The salivary flow rate is reduced due to the medication.
Other: N/A

Treatment plan: The patient receives advice in home care plaque control at today's supportive periodontal maintenance visit (following the oral health assessment). She continues with her 3 monthly periodontal maintenance visits and is recalled for her oral health assessment in 6 months.

Recall Interval recommended by the clinician for oral health review:
6 months

Rationale: The response to periodontal therapy is good in the less severely affected areas. Plaque control is variable and in conjunction with the risk factors of heavy cigarette smoking and reduced salivary flow rate, the risk of disease is high. The removable partial denture might also act to favour plaque accumulation.

SCENARIO R

Age: Patient is an 18-year-old male.
Attendance Record: This patient has been visiting your practice for the last 6 months only.
Medical History: Clear
Social History: The patient is a non-smoker with a moderate alcohol intake of 12 units per week.
Dietary habits: Irregular meals with periods of an unbalanced diet.
Use of fluoride: The patient now brushes twice a day with a fluoride-containing toothpaste.
Clinical evidence and dental history: Initially, localised moderately deep pockets were limited to some first molars and incisors. This led to a diagnosis of localised aggressive periodontitis. Home-care plaque control advice and non-surgical therapy produced substantial improvements with pockets of 3-4mm present (maximum BPE 3).
Plaque: The patient brushes twice a day with and uses floss daily. After a hesitant start, the plaque score has now reduced to 17%.
Saliva: The salivary flow rate is normal.
Other: N/A

Treatment plan: The patient receives advice in home care plaque control at today's supportive periodontal maintenance visit (following the oral health assessment). He continues with 3-monthly periodontal maintenance visits and is recalled for her oral health assessment in 3 months.

Recall Interval recommended by the clinician for oral health review:
3 months

Rationale: The response to periodontal therapy is good but the potential for rapid progression of aggressive periodontitis must be considered. Once, the stability of the periodontal status is known, the clinician could consider reducing the frequency of oral health reviews if this is appropriate (based on clinical status and risk factors). The frequency of supportive maintenance visits should remain at 3 months.

SCENARIO S

Age: Patient S is a 35-year-old female
Attendance Record: Patient S has been attending your practice regularly for 6 years.
Medical History: Patient has no medical history of note. There is no family history of diabetes.
Social History: Patient does not smoke and drinks alcohol occasionally at the weekends.
Family History: Patient has no family history of periodontal disease nor of early tooth loss.
Clinical Evidence and dental history: Patient P1 has no missing teeth. Her gingival health looks excellent and she reports no bleeding on brushing, no mobility or drifting of her teeth. Periodontal screening reveals a BPE code of 0 with no pockets deeper than 3.5mm and no bleeding on probing. Bitewing radiographs taken 12 months ago revealed no interproximal bone loss on posterior teeth. Similarly, her restorations are not plaque retentive.
Plaque: Patient P1 brushes twice a day and uses dental floss once a day. She has not needed a scale and polish for over 3 years.
Saliva: Patient P1 has a normal salivary flow rate.
Other: N/A

Recall Interval recommended by clinician for oral health review:
24 months

Rationale for 24 month interval: Over a 6-year period at your dental practice, this patient has required only scaling and polishing to remove stain and calculus but has not required any periodontal intervention. The patient has not developed any periodontal pockets over a 15-year period and has excellent oral hygiene and dietary habits and can be described as excellent. There is no discomfort arising from her periodontal tissues and the she is very happy with this situation. The patient's dental status appears stable at this point in time suggesting that a recall interval of 24 months is appropriate for this patient. However, you inform the patient that they should reattend before this time if there is any change in their medical history, dietary habits, oral hygiene practices *etc* that may impact on their oral health, or if they experience any signs or symptoms of oral disease.

SCENARIO T

Age: Patient T is a 21-year-old male
Attendance Record: Patient has been attending your practice intermittently for two years.
Medical History: Patient has no medical history of note. However, his mother and maternal grandfather both have type II diabetes.
Social History: Patient smokes 20 cigarettes a day and has done so for the past 4 years. He drinks alcohol at the weekends and also some evenings.
Family History: Patient has a strong family history of periodontal disease with both parents having lost all teeth in their 30s.
Clinical Evidence and dental history: Patient has already lost 2 first molar teeth. His gingival health is poor with inflammation present at a number of interproximal sites. He reports regular bleeding on brushing which he tends to ignore, but no significant mobility or drifting of her teeth. Periodontal screening reveals a BPE code of 4 with a number of no pockets deeper than 3.5mm and several around his first molar teeth deeper that 5.5mm. There was widespread bleeding on probing. Bitewing radiographs taken 12 months ago clearly revealed interproximal bone loss on posterior teeth. Similarly, he has a number of large restorations which are in contact with the gingival margins and are plaque retentive.

Plaque: Patient brushes twice a day but does not use any interproximal cleaning aids. He has needed a scale and polish every 3-6 months over the past 2 years.
Saliva: Patient has a normal salivary flow rate.
Other: N/A

Recall Interval recommended by clinician for oral health review:
3 months

Rationale for 3 month interval: Patient has multiple risk factors for the development of periodontal disease. Irregular scaling over the past 2 years has not been sufficient to halt the progress of the disease and there are now clear signs of periodontal destruction such that a diagnosis of Aggressive Periodontitis can be made. There is no discomfort arising from his periodontal tissues but he is unhappy that his gums bleed on brushing. The patient's dental status appears unstable at this point in time suggesting that a recall interval of 3 months is appropriate for this patient. If he responds well to treatment it may be possible to lengthen this recall interval.

Appendix C: The Guideline Development Group

Professor Nigel Pitts	Chair, Dental Health Services Research Unit, University of Dundee
Dr Paul Batchelor	British Association for the Study of Community Dentistry
Dr Jan Clarkson	Cochrane Oral Health Group
Dr Clare Davenport	West Midlands Health Technology Assessment Collaboration
Mr Ralph Davies	British Dental Association
Miss Karen Elley	Sandwell Primary Care Trusts
Mr Stephen Fayle	Faculty of Dental Surgery, Royal College of Surgeons of England
Mrs Eleanor Grey	Patient Representative, Chair, Lay Advisory Group, Faculty of General Dental Practitioners
Miss Kathryn Harley	Faculty of Dental Surgery, Royal College of Surgeons of England
Miss Sara Hawksworth	Patient Representative, Age Concern England
Professor Mike Lewis	University of Wales College of Medicine
Mr Peter Lowndes	Faculty of General Dental Practitioners
Mr Mike Mulcahy	Faculty of General Dental Practitioners
Mr Derek Richards	Centre for Evidence Based Dentistry
Mr Richard Seppings	British Dental Association
Dr Graham Smart	Faculty of Dental Surgery
Mrs Elaine Tilling	British Dental Hygienists Association
Mr Peter Wilkins	Faculty of General Dental Practitioners
Professor Helen Worthington	Cochrane Oral Health Group

Appendix D: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring its quality. The Panel includes experts on guideline methodology, health professionals and people with experience of the issues affecting patients and carers. The members of the Guideline Review Panel were as follows.

[NICE to add]