Guidelines for Considering Teeth for Treatment or Extraction

- Irritation caused by sharp edges of teeth, orthodontic brackets, defective restorations, or defective prosthesis should be corrected.
- Carious lesions and recurrent carious lesions should be restored.
- Deep pits and fissures should be sealed to reduce the probability of carious lesions in future.
- Any carious lesions that potentially threaten pulpal integrity should be treated with endodontic therapy or extracted.
- Any periapical lesions greater than the diameter of 3 mm in diameterradiographically should be considered for extraction, however, periapical lesions less than 3 mm diameter should be endodontically treated. If the prognosis of endodontics is poor it is better to extract the teeth.
- Patients with calculus build up and deep pockets should be treated with scaling and root planing.
- If pocket depths exist which are more than 5-6 mms, extraction of the involved teeth should be considered.
- Teeth with root furcation involvement (Class II) should also be considered for extraction as the teeth can become sources of infection.
- Non strategic teeth(e.g., not in occlusion) should be considered for extraction.
- Teeth with mobility greater than 2 should be considered for extraction.
- Teeth with large restorations with potential to fracture or which threaten pulpal integrity should be considered for extraction.
- Partially impacted wisdom teeth should be considered for extraction.

Patient at Home Regimen: During and Post-Radiation

- Brush teeth with prescription fluoride toothpaste (do not rinse afterwards). At night brush ½ hour before bedtime.
- Apply MI Paste Plus 3-4 times a day and directly before going to bed.
- Do not brush immediately after meals. Brushing may increase the risk of tooth surface loss.
- Rinse with Caphosol®, Neutrasol®, or plain water with baking soda rinse (1tsp baking soda in 8 oz. water) after meals and snacks.
- Chew gum containing xylitol throughout the day. A piece of chewing gum in the mouth can stimulate salivary flow from remaining functional glands in case of TMJD.
- Brush teeth and tongue with powered (sonic) toothbrush with gentle pressure.
- Use a prescription sialogogue (Pilocarpine or Cevimeline) up to 3-4 times/day. Also,during radiation treatment, take a tablet/capsule 1 hour prior to treatment.
- Low fluoride containing rinse after meals (especially after acidic meals).
- Post-radiation— Break Vitamin E capsules in mouth, swish and spit up to 3 times a day. Keep a humidifier in the room set at 50% at night.
- Use other sugar/alcohol free oral comforting over the counter agents if relief is perceived.
- Visit the dentist every three months for a complete exam, cleaning, and topical fluoride treatments.
- Restore teeth as soon as carious lesions appear.
- Frequent large sipping or drinking of water does not help relieve dryness of the oral cavity. Try taking small sips to wet the oral mucosa which gives the sensation of wetness in the gum mouth and does not wash away salivary proteins.

References: http://www.cancer.gov/cancertopics/treatment/head-and-neck, http://www.nidcr.nih.gov/OralHealth/Topics/CancerTreatment/Head NeckRadiation.htm, http://www.mdanderson.org/patient-and-cancer-information/care-centers-and-clinics/care-centers/head-neck/index.html, Shiboski CH, Hodgson TA, Ship JA, Schiødt M. Management of salivary hypofunction during and after radiotherapy. Oral Surg Oral Med Oral Pathol Oral Radiol Endod 2007; 103 (suppl 1): S66.e1-S66.e19. Jellema AP, Slotman BJ, Doornaert P, et al. Impact of radiation-induced xerostomia on quality of life after primary radiotherapy among patients with head and neck cancer. Int J RadiatOncolBiolPhys 2007; 69(3): 751-60. Sonis ST, Elting LS, Keefe D, et al. Perspectives on cancer therapy-induced mucosal injury: pathogenesis, measurement, epidemiology, and consequences for patients. Cancer 2004; 100 (9 Suppl):1995-2025.