



AMERICAN ACADEMY
OF CRANIOFACIAL PAIN

AUSTRALIAN CHAPTER

President: Nichal Singh
Secretary-Treasurer: Darryl Moses
Education Officer: Karen McCloy
Committee Members: Scott Robertson
Andrew Lee
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Executive Officer
National Board of Australia
AHPRA
GPO Box 9958
Melbourne 3001

June 18th 2013

Dear Sir/Madam

RE Draft Scope of Practice Registration Standard and Guidelines, 8th May 2013

**Dental prosthetists are members of the dental team.
They work as independent practitioners in a range of activities included in the definition of dentistry.**

The Australian Branch of the American Academy of Craniofacial Pain (AACFP) is an organization for Dentists, Specialist Dentists and affiliated professionals who have an interest in treating patients with craniofacial pain and sleep disorders as part of a structured relationship with GP and specialist medical practitioners.

Our organization provides regular clinical and scientific educational activities for our members, and we are committed as a group to improving the dental professions knowledge and application of skills in the areas of sleep dentistry and craniofacial pain. As a group we are concerned about the proposed provisions of the Dental Board to allow Dental Prosthetists to supply various types of splints and sleep apnoea/ anti-snoring devices to the public.

Our concern regards provision of splints:

There is a vast array of splint designs used by the dental profession, and they are used for many purposes, which include, but are not limited to jaw stabilization after trauma/ fracture, tooth protection guards, and the treatment of orofacial pain. The decision as to when and how they should be applied requires a thorough grounding in the diagnosis of orofacial pain and movement disorders. An appliance which is supplied and fitted incorrectly, or for an inappropriate reason may do more harm than good, and may result in facial pain, disc displacement of the temporomandibular joint, sleep apnoea, and bite changes¹. The AACFPs major concern are in the involvement of prosthetists in fitting appliances used for the treatment of craniofacial pain and bruxism.

Bruxism has been thought of as benign by the dental profession until recently with the input from our sleep medicine colleagues. Nocturnal bruxism can result in the loss of tooth structure, and may be implicated in



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myofascial and arthrogenous temporomandibular disorders¹. Daytime bruxism may be the result of a medical disorder, or the treatment of that disorder. Nocturnal bruxism is associated with sleep apnoea, and especially with patients with sleep arousals who dip in and out of apnea^{2,3}. A flat plane maxillary splint of the kind most commonly made as a bruxism guard may exacerbate sleep apnoea². Most sleep apnoeics do not suffer from sleep apnea syndrome⁴, and may not have symptoms associated with a worsening of their condition, and diagnosing this issue requires the experience of a Dental Practitioner with a high degree of training in the sleep apnoea field.

Pain can be both chronic (lasting more than 3 months) and acute. Acute pain is relatively simple to diagnose and treat, whereas chronic pain involves suffering and may have symptoms which are not related to the original cause of the pain⁵. A working diagnosis is made based on a thorough clinical examination and history taking. If it is decided that an occlusal appliance would be beneficial, it is fabricated and the change in the symptoms is monitored. Due to the complexity of chronic pain, the original working diagnosis may be incorrect, and the clinician's diagnostic skill is needed again to modify the diagnosis and treatment plan¹. This will not be possible in cases where a prosthetist is fitting the occlusal appliance, as even with "add on courses" they will not have the skill to diagnose both intra and extra cranial sources of orofacial pain. Failure to reach a correct diagnosis and treatment plan may result in medical conditions which can mimic temporomandibular disorders such as ischaemic heart failure⁶⁻⁸ and tumours⁹. This can have life threatening consequences for the patients at worse, and result in escalation or prolongation of pain at best.

Our concern regards treatment of snoring and sleep apnoea:

Oral appliance therapy (OAT) is now recognised as an effective therapy for OSA for patients with snoring and mild to moderate OSA¹⁰. It is also used in the case of CPAP intolerance for severe OSA. Appliances are currently fitted only by Dentists and rebated by most health funds only when a referral to the Dentist has been made by the Sleep Physician or Medical Practitioner. In all cases managing OSA rather than simple snoring, the Dentist is required to work as part of a multi-disciplinary team led by the sleep physician or at least the Medical Practitioner. Co-management ensures that the careful titration (adjustments) of the appliances required to reach a therapeutic outcome is followed up with review by the referring Medical Practitioner initially involved. Communication between team members is of the highest importance for the effective management of OSA as follow up using further polysomnography (sleep study) is required to ensure that the appliance is of therapeutic benefit. Symptomology in OSA is a very poor determinant of the therapeutic effectiveness of the appliance and as such close medical supervision is required¹¹.

It is known that OAT can cause a change to the bite or induce TMJ pain or dysfunction. These undesirable outcomes are commonly the cause of the patient ceasing use of the appliance^{10,12}. If they are not under the careful supervision of a team then the treatment for their serious medical condition may cease. Significant co-morbidity of OSA and TMD is well documented^{13,14}; therefore pre-treatment diagnosis of potential disorders is



of utmost importance to the design and management of any appliance. Pre-treatment diagnosis of potential TMJ dysfunction we believe is beyond the scope of training of in “add on course” for a Dental Prosthetist. Poor outcomes are extremely likely if TMD/orofacial pain is not understood or managed pre-treatment. If TMJ pain commences during appliance titration then recognition, diagnosis and management of the problem requires a detailed working knowledge of the TM joint and associated structures. We believe that this is also beyond the scope of training in an “add-on course” for dental prosthetists. Poor management of an oral appliance during OSA treatment can either compromise the outcome of treatment¹² or worse still rule out future use of that treatment option, leaving only more invasive treatment modalities available to the patient.

In summary the position of the AACFP Australian branch is that Dental Prosthetists should not be able to supply splints for the treatment of craniofacial pain even when referred and initially diagnosed by a dental practitioner because

1. Treatment of orofacial pain and bruxism requires ongoing diagnostic ability which the Prosthetist (and general Medical Practitioner) will not have.
2. The quality of treatment for craniofacial pain patients will decrease, and this may result in more suffering.
3. The Dental Prosthetists are not trained to recognize or deal with alterations to the bite, increases in temporomandibular joint pain which may occur, especially given the anticipated decrease in quality of care. These changes may be both significant and permanent.
4. This will result in an increase in the need for visits to medical and dental practitioners, not a decrease and improvement of care, and an end result of increase time suffering and money
5. OSA is a growing medically significant disorder with associated risk of organ morbidity and mortality and poor management carries significant health consequences¹⁵.
6. The changes in the current proposal take us away from the direction that equivalent countries such as the USA and Canada¹⁶ are taking in the management of these disorders under suggestion from bodies such as the American Dental Association, American Academy of Sleep Medicine¹⁰, American Board of Craniofacial Pain and the American Board of Orofacial Pain.
7. The ease of fitting a dental appliance for either sleep disorders or craniofacial pain belies the skills required to assess, diagnose and manage either the original disorder or any disorders that result from the use of the appliance.
8. The majority of patients are not cured of OSA but require lifelong multi-disciplinary management, with expert regular follow up to avoid significant medical complications¹⁷. In a society with rapidly increasing obesity, one of the most significant contributors to the development of OSA, the decisions made now about management for this disorder we believe have the potential for enormous impact on future medical expenditure, both in resources and funding.



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We understand that historically legislation such as this has sought to increase access to care for the public in a structured professional environment. The same intent was in place when Prosthetists were first allowed to fabricate partial dentures for the public following referral to a general Dental Practitioner. This approach did not occur for longer than a minimum time frame, and dentures are now made without any prior examination or requisite dental treatment. Based on past events it is therefore not unreasonable to assume that this may well be the eventual outcome if Prosthetists are permitted to make sleep appliances and splints for the public, despite the Dental Boards good intention to maintain a structured professional environment. In the case of partial dentures failure to follow Dental Board guidelines may have resulted in the need for larger filling, or at worst a loss of a tooth, which could have been saved. In the management of sleep apnoea and facial pain, the result will be an increase in suffering and possibly the loss of life. We believe that the Australian public deserves a better quality of care than this.

We are happy for you to publish our submission on your website.

Yours sincerely,

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