# COLLEGE OF DENTAL HYGIENISTS OF ONTARIO ADVISORY

## ADVISORY TITLE

Use of the dental hygiene interventions of scaling of teeth and root planing including curetting surrounding tissue, orthodontic and restorative practices, and other invasive interventions for persons\(^1\) with bipolar disorder.

## ADVISORY STATUS

Cite as

*College of Dental Hygienists of Ontario, CDHO Advisory Bipolar Disorder, 2017-11-30*

## INTERVENTIONS AND PRACTICES CONSIDERED

Scaling of teeth and root planing including curetting surrounding tissue, orthodontic and restorative practices, and other invasive interventions (“the Procedures”).

## SCOPE

### DISEASE/CONDITION(S)/PROCEDURE(S)

- **Bipolar disorder**

### INTENDED USERS

<table>
<thead>
<tr>
<th>Advanced practice nurses</th>
<th>Nurses</th>
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<tr>
<td>Dental assistants</td>
<td>Patients/clients</td>
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<tr>
<td>Dental hygienists</td>
<td>Pharmacists</td>
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<td>Dentists</td>
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<td>Denturists</td>
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## ADVISORY OBJECTIVE(S)

To guide dental hygienists at the point of care relative to the use of the Procedures for persons who have bipolar disorder, chiefly as follows.

1. Understanding the medical condition.
2. Sourcing medications information.
3. Taking the medical and medications history.
4. Identifying and contacting the most appropriate healthcare provider(s) for medical advice.

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\(^1\) Persons includes young persons and children
5. Understanding and taking appropriate precautions prior to and during the Procedures proposed.
6. Deciding when and when not to proceed with the Procedures proposed.
7. Dealing with adverse events arising during the Procedures.
8. Keeping records.

TARGET POPULATION

Adolescent (13 to 18 years)
Adult (19 to 44 years)
Middle Age (45 to 64 years)
Aged (65 to 79 years)
Aged, 80 and over
Male
Female

Parents, guardians, and family caregivers of children, young persons and adults with bipolar disorder.

MAJOR OUTCOMES CONSIDERED

For persons who have bipolar disorder: to maximize health benefits and minimize adverse effects by promoting the performance of the Procedures at the right time with the appropriate precautions, and by discouraging the performance of the Procedures at the wrong time or in the absence of appropriate precautions.

RECOMMENDATIONS

UNDERSTANDING THE MEDICAL CONDITION

Terminology used in this Advisory

Resources consulted

- Bipolar disorder: PubMed Health
- Canadian Mental Health Association
- Centre for Addiction and Mental Health
- Family Practice Notebook
- MedicineNet.com
- Mood Disorders Society of Canada

Terminology varies among clinical centres. The following reflects common though not necessarily universal usages.

Bipolar disorder, manic depression, bipolar affective disorder, manic-depressive illness
1. is a serious mental illness, the manifestations of which include episodes of depression or mania, or both, with potentially grave consequences including suicide
2. is experienced by the person as mood swings, which
   a. can be extreme, back and forth between the manic phases and depressive phases
   b. are not necessarily related to the person’s life events
c. affect thinking, behaviour and functioning
d. result in loss of the normal sense of control over mood, a loss that causes distress.

Other terminology used in this Advisory is as follows.

1. Catatonic, catatonia, disturbances of movement including immobility, excessive motor activity, purposeless agitation, and posturing or stereotyped movements.
2. Cyclothymia, mild form of bipolar disorder in which the mood swings
   a. are less severe than bipolar-I or bipolar-II disorder
   b. alternate between hypomania and mild depression.
3. Delusions, beliefs unfounded in reality.
4. Depressive phase of bipolar disorder, is manifested by
   a. daily mood lows or sadness
   b. difficulty concentrating, remembering, or making decisions
   c. eating problems
      i. loss of appetite and weight loss
      ii. overeating and weight gain
   d. fatigue or lack of energy
   e. feelings of worthlessness, hopelessness, or guilt
   f. loss of pleasure in activities once enjoyed
   g. loss of self-esteem
   h. thoughts of death and suicide
      i. getting to sleep
      ii. sleeping excessively
   j. withdrawal from
      i. relationships with friends
      ii. activities that were once enjoyed.
5. Depression, a condition that arises in connection with bipolar disorder and other mental health conditions, and that also is an independent illness (CDHO Advisory), which
   a. affects the emotions, relationships and behaviour and also physical health
   b. in serious form affects some nine percent of Canadians at any one time
   c. is roughly twice as common in women as in men
   d. takes many forms, and often strikes without warning
   e. is confidently diagnosed when the symptoms endure at least two weeks, are present most days and for most of the day.
   f. in bipolar disorder, is defined by symptoms that include at least five of the following, in which the person exhibits or experiences
      i. depressed mood, which differs markedly from and may even preclude normal sadness until the depressed mood begins to lift
      ii. marked loss of interest or pleasure in activities previously enjoyed; in severe depression, pleasurable activities do not provide relief or diversion
      iii. weight loss or gain; one person may lose the appetite; another may develop food cravings; the metabolism may change accordingly
      iv. sleep problems, which are common in depression, involving
         1. troublesome insomnia leading to feelings of exhaustion, including
a. difficulty falling asleep
b. waking up frequently during the night
c. awakening too early in the morning

2. oversleeping, especially during the day
   v. apathy; slowness of movement, speech or thinking, even to the extent of inability to move, speak and even respond to the environment
   vi. agitation; severe and disturbing inner restlessness, inability to sit still, with pacing, wringing of hands and other displays of agitation; feelings of considerable anxiety
   vii. loss of energy; difficulty or slowness in completing everyday activities
   viii. feelings of worthlessness and guilt arising from poor self-confidence: weak assertiveness, overwhelming feelings of worthlessness, obsessions with guilt or previous failure which may develop into delusions of punishment for past mistakes
   ix. inability to concentrate or to make decisions to an extent that impairs performance of simple tasks or impedes decisions on trivial matters
   x. suicidal thoughts arising from the belief that life is not worth living
   xi. psychotic symptoms; false beliefs about poverty, punishment or disease, or auditory or visual hallucinations.

6. Hallucination, hearing voices, the most common hallucination, that comment on behaviour, are insulting or give commands; or seeing, tasting, smelling or feeling something that has no basis in reality.

7. Hypomania, symptoms that
   a. are less severe than those of mania, but may still be disruptive
   b. may progress to full manic episode or severe depression
   c. need treatment.

8. Mania, a mental state comprising an abnormal, continuous ‘high’, irritability or expansiveness, which
   a. lasts for at least a week and is manifested by
      i. decreased need for sleep
      ii. euphoria
      iii. exaggerated self-esteem
      iv. extraordinary optimism
      v. extreme irritability
      vi. impulsive and potentially reckless behaviour
      vii. racing thoughts
      viii. rapid speech
   b. occurs with various comorbidities, complications and associated conditions
   c. occurs with various medications, such as
      i. antidepressants
      ii. captopril
      iii. corticosteroids
      iv. hydralazine
      v. isoniazid
      vi. monoamine oxidase inhibitors.

9. Manic phase of bipolar disorder, is
   a. a mental state of marked irritability, anger, agitation, disruptiveness, aggression, euphoria and reckless behaviour and lack of self-control resulting in
i. binge eating, drinking, and substance abuse (CDHO Advisory)
ii. impaired judgment
iii. promiscuity
iv. spending sprees

b. experienced in severe form by only a small percentage of people with bipolar disorder

c. accompanied by definite manifestations of at least three of the following
   i. exaggerated self-esteem, or feelings of grandeur, invincibility or possession of special powers, understanding, or life mission
   ii. reduced need for sleep; rested after only a few hours of sleep; or sleeplessness for days or even weeks
   iii. increased talking; more than normal, rapidly, and too loudly; frequent switching of topics, inability to converse properly with others; sometimes with expression of anger if interrupted
   iv. flight of ideas or racing thoughts; loss of train of thought, easily distracted; impatience with others who cannot understand or keep up
   v. accelerated activity; socialization to an unusual degree at work or school; unusually active; boundless energy; frantic, unproductive activity as symptoms develop
   vi. impaired judgment, inability to control or plan; making bad decisions, or participating in unusual or risky activities without concern for harmful consequences
   vii. psychotic symptoms: delusions or hallucination.

10. Mixed state episodes, in which manic and depressive symptoms occur together; difficult to diagnose and troublesome for the person.

11. Neurotransmitters, natural chemicals involved in the functioning of the nervous system.

Overview of bipolar disorder

Resources consulted
- Bipolar Disorder (Mania): MedicineNet.com
- Bipolar Disorder: An Information Guide | Centre for Addiction and Mental Health
- Bipolar Disorder: Canadian Mental Health Association
- Bipolar Disorder: Pendulum.org
- Bipolar disorder: PubMed Health
- Mania Secondary Causes: Family Practice Notebook
- What is Depression?: Mood Disorders Society of Canada

Occurrence
- Bipolar disorder
  1. occurs in about one to two percent of the population
  2. typically starts in late adolescence or early adulthood
  3. affects men and women equally
  4. may appear in some women during or shortly after pregnancy as
     a. hypomania, which occurs in 10–20 percent of women immediately after childbirth, and which may be confused with the natural joy following childbirth, and which may also be accompanied by depression
b. **depression**, which occurs more commonly, and which requires medical investigation if depressive symptoms after pregnancy are severe or last more than two weeks, and which may be manifested by symptoms such as
   i. severe anxiety
   ii. worries about small matters
   iii. complaints about physical symptoms, including pain
   iv. many visits to the family physician for various physical symptoms

c. **mania**, which occurs rarely

5. presents as three types
   a. bipolar-I disorder, characterized by
      i. at least one manic episode
      ii. episodes of major depression
   b. bipolar-II disorder, characterized by
      i. **hypomania**
      ii. alternation of hypomania with episodes of depression
      iii. absence of full **mania**
   c. **cyclothymia**

6. is episodic in pattern
   a. averaging in a lifetime some ten episodes that increase in frequency as age advances, with unpredictable gaps of weeks, months or years
   b. comprising episodes appearing in no fixed order, which may involve
      i. **mania**, the high state which, if untreated, may last two to three months
      ii. **depression**, the low state which, if untreated, may last four to six months
      iii. the well state, in which feelings and functions are normal or nearly so
   c. with variations in the nature of the episodes.

**Cause**

**Bipolar disorder**

Is of unknown cause though factors important in its development are recognized, including

1. a tendency to run in families, which may be
   a. congenital, acquired during development in the uterus and not inherited
   b. inherited
2. abnormalities of or that affect **neurotransmitters**
3. triggers of episodes, such as
   a. severe stress
   b. life changes such as childbirth
   c. continuing loss of sleep
   d. medications, such as
      i. **antidepressants**
      ii. **steroids**
      iii. substances of abuse (**CDHO Advisory**) such as
         1. amphetamines
         2. cocaine.

**Risk factors**

**Bipolar disorder**

1. High risk of **suicide**, which
a. arises in the **manic phase** and the **depressive phase**
b. represents an immediate emergency for persons with bipolar disorder who think or talk about suicide.

2. Risk of abuse of alcohol or other substances, which increases
a. symptoms of bipolar disorder
b. suicide risk.

**Signs and symptoms**

**Bipolar disorder**
1. **manic phase**
2. **depressive phase**.

**Medical investigation**

**Bipolar disorder**

Is complicated by difficulties in diagnosis because
1. in its early stages
   a. the younger the person when the symptoms first develop, the more atypical are the symptoms
   b. the symptoms may be mistaken for teenage distress or rebellion, and delay diagnosis until adulthood
2. of **catatonia** which
   a. in 25 to 28 percent of persons with bipolar disorder occurs in the episodes
   b. is strongly associated with schizophrenia
3. it may be incorrectly diagnosed as depression
4. of the numerous factors in the medical and medications history that require analysis, including
   a. family medical history of bipolar disorder or conditions resembling it
   b. family members’ perceptions of the person’s moods and behaviour
   c. occurrences and patterns of mood swings and behavioural disorders
   d. **comorbidities, complications and associated conditions**
   e. medications history
   f. substance dependence, which may
      i. cause symptoms similar to those of bipolar disorder
      ii. signal bipolar disorder.

**Treatment**

**Bipolar disorder**
1. offers no known cure
2. requires that the person, friends, and family must know the risks of
   a. not treating bipolar disorder
   b. stopping medications, which may lead to
      i. suicidal thoughts and behaviour
      ii. alcohol and/or drug abuse
      iii. problems with relationships, work, and finances
3. confronts particular challenges, such as
   a. inability of the person to recognize the
      i. state of the illness
      ii. manic symptoms as such
b. unpredictability of mood changes
    c. uncertainty about treatments for children and the elderly
4. requires caution in the choice of treatment children and adolescents
5. may require hospitalization to stabilize mood and behaviour for persons in severe manic or depressive episodes
6. can enable most persons to work with their healthcare providers and family caregivers, and to return to school or work
7. offers options such as
   a. medications, usually the first priority, to
      i. provide relief for symptoms
      ii. stabilize moods
   b. electroconvulsive therapy an effective though controversial treatment
   c. transcranial magnetic stimulation, the effectiveness of which is not yet established
   d. psychosocial treatments, such as
      i. psychoeducation, which is health education specifically for psychiatric illnesses, and which provides instruction on
         1. causes of the illness
         2. treatment
         3. self-management for a balanced, healthy lifestyle, including
            a. avoidance of alcohol and substances of abuse
            b. healthy diet, exercise, and oral hygiene
            c. regular sleep patterns
            d. coping with and avoiding stress
            e. avoidance of isolation
            f. self-monitoring and monitoring by family and family caregivers for symptoms, such as subtle mood changes, that signal impending relapse
      4. prevention of future episodes
     ii. psychotherapy, treatment based on discussion with a therapist whom the person trusts and is comfortable with, which is positioned as a complement to medications, and which is intended to provide practical suggestions and emotional support for
         1. relieving distress by discussing and expressing feelings
         2. helping change counterproductive attitudes, behaviour and habits
         3. promoting constructive and adaptive ways of coping
    iii. support groups, composed of persons who all have bipolar disorder, who accept and understand one another, and who can share their experiences with others who have “been there”
8. includes special arrangements, including hospitalization, which
   a. may be necessary during severe episodes of depression or mania if the illness is out of control to the extent of putting the person at risk of serious consequences, such as suicide
   b. may be on a voluntary or, in pressing circumstances, an involuntary basis subject to various legal safeguards
   c. may involve in-patient stays from a few days to several weeks, with increasing freedom of movement as the condition improves
d. emphasizes discharge planning to ensure that the person
   i. is discharged as soon as safe functioning is restored
   ii. will receive
      1. adequate care or self-care at home
      2. suitable follow-up
9. recognizes as a medical emergency symptoms indicative of rising risk of suicide, including
   a. thoughts of death and suicide
   b. deepening depression
   c. in persons under treatment
      i. return of symptoms
      ii. emergence of new symptoms
10. reflects the recovery process of episodes
    a. which may be gradual and frustrating because it extends over a period of months although the symptoms of the most recent episode may be gone
    b. during which the person is likely to
       i. feel fragile and vulnerable to further episodes
       ii. experience only slowly a return to self-confidence and normalcy
       iii. require a recovery strategy that balances activities, interests, and work appropriately for the person’s abilities
       iv. require medications for treatment and also for prevention of return of symptoms or relapse, and which must be taken for long periods or indefinitely
11. requires a treatment plan that aims to
    a. treat symptoms until these no longer cause distress or problems
    b. help the person and the family caregiver to
       i. detect patterns and triggers of episodes
       ii. develop strategies for managing stress and emotional problems
    c. improve work and social functioning
    d. reduce
       i. risk of relapse
       ii. frequency of episodes
    e. avoid need for hospitalization.

Prevention

Bipolar disorder
1. Cannot be prevented.
2. Can be helped by prompt and appropriate treatment.

Prognosis

Bipolar disorder
1. reflects the nature of bipolar disorder as a long-term condition without cure that
   a. is associated with real risk of suicide
   b. can be supported by treatments to control symptoms
2. varies
   a. in severity, frequency and total number of episodes, which
      i. typically average 8–10 manic or depressive episodes over a lifetime
      ii. may leave some persons struggling with mood swings for the remainder of their lives
b. according to treatment
   i. with treatment
      1. many persons are able to lead normal lives but often need help and support
         a. with medication compliance
         b. to ensure that mania and depression are treated promptly
      2. some 10 percent may be spared another manic episode
   ii. without treatment
      1. is associated with higher-than-expected death rates associated with
         a. suicide
         b. heart disease
         c. death from all causes
      2. may lead to
         a. risky activities
         b. dysfunction in family and work
         c. homicide

b. according to the attention paid to signs and symptoms of emerging depression or mania
   i. by persons monitoring themselves
   ii. by families and friends of the person recognizing warning signs and symptoms.

Social considerations

Bipolar disorder
1. requires family and family caregiver support because
   a. like all chronic illnesses, it affects the entire family, and not only the person with the illness
   b. it brings conflicting emotions, extra stress and unexpected stressors for family caregivers
   c. it may create particular tensions within the family during the manic and depressive phases of the illness, which may be distressing, and severe mood swings, which may be difficult to handle
   d. for the family as a whole, it may create stress intense enough to undermine the health and activities of the family caregiver and others, and which as a result may increase difficulties that are not always adequately understood by healthcare providers, who should be on the lookout for opportunities to be informally supportive of family caregivers
   e. it carries an aura of stigma despite much social action to dispel prejudice
2. requires treatment that can be challenging for the family caregiver when the
   a. person experiences difficulty in accepting the need for ongoing treatment for the remainder of their lives, or may even need to live through several manic or depressive episodes before consistently accepting help from physicians and therapists
   b. person is severely depressed and suicidal and refuses to be treated
   c. person is in the hypomanic phase, with its feelings of happiness, confidence, energy and creativeness, a phase which, to avoid development of full mania,
requires immediate medical attention with medication that the person may refuse, leading to tensions with the family caregiver
d. circumstances involve mental health laws that place limits on enforced hospitalization
e. family caregiver feels guilty in having to invoke formal procedures which may even involve authorization for removal by police when, for example, suicide is threatened or when the manic episode causes the person to behave dangerously with the potential for serious consequences
f. family caregiver contends with non-compliance with treatment and experiences challenges in providing support in complex circumstances such as
   i. relapse or crisis, which requires anticipation in the form of uncomfortable discussions and realistic planning, including written, signed agreements for procedures to be followed, such as advance permission for the family caregiver to contact the primary care physician if relapse appears impending; the planning should include the physician
   ii. lack of necessary knowledge about the illness and its treatment on the part of the family caregiver, especially relating to
      1. the warning signs of suicide
      2. effective methods of supporting the person in recovery from an episode, often a slow and sometimes a frustratingly gradual process
      3. reasons why bipolar disorder should always be viewed as an illness and not as a character flaw or weakness
      4. methods for handling bad as well as good days, which may in fact be normal variation

3. involves support programs
   a. for families of persons diagnosed with bipolar disorder
   b. outreach programs for persons without families or sufficient social support.

Multimedia and images

**Bipolar disorder**

**Comorbidity, complications and associated conditions**

Comorbid conditions are those which co-exist with bipolar disorder but which are not believed to be caused by it. Complications and associated conditions are those that may have some link with it. Distinguishing among comorbid conditions, complications and associated conditions may be difficult in clinical practice.

Comorbid conditions, complications and associated conditions for bipolar disorder
1. may
   a. confuse the clinical picture and complicate treatment
   b. be of such severity that they require prompt and effective treatment
   c. be responsible for mania, for example
      i. nutritional disorders [CDHO Advisory] including
         1. folate Deficiency
         2. niacin Deficiency
3. thiamine Deficiency
4. vitamin B12 Deficiency

ii. head trauma
iii. herpes encephalitis
iv. HIV/AIDS (CDHO Advisory)
v. hyperthyroidism (CDHO Advisory)
vi. hypothyroidism (CDHO Advisory)
vii. influenza
viii. multiple sclerosis (CDHO Advisory)
ix. neurosyphilis
x. stroke (CDHO Advisory)
xi. substances of abuse (CDHO Advisory)

2. include
   a. substance or alcohol abuse (CDHO Advisory) in which
      i. mania may
         1. exacerbate existing alcohol problems
         2. lead to involvement with substances of abuse because of impulsiveness or loss of normal caution
      ii. depression may increase alcohol consumption or substance abuse
         1. because these may afford some relief from the depression
         2. though the excessive alcohol consumption or substance abuse may not extend to the well phase
   b. other psychiatric conditions such as
      i. panic disorder
      ii. obsessive-compulsive disorder
      iii. binge-eating disorder
   c. medical conditions arising from inadequate self-care, substance abuse, poor compliance with treatment and risky behaviour.

Oral health considerations

Resources consulted
- Bipolar affective disorder and the dental hygienist
- Dental care for the patient with bipolar disorder

With the intention of maintaining oral health, comfort and function, and of preventing and controlling specific oral disease, oral healthcare can be delivered safely and beneficially for persons with bipolar disorder by the dental hygienist who
1. provides treatment and preventive education relative to
   a. the particular impairments brought by bipolar disorder to oral health, especially
      i. weakening of self-care causing neglect of oral health
      ii. negative feelings of self-worth
      iii. mood swings reflected in
         1. depressive episodes commonly associated with decline in oral hygiene leading to
            a. increase in dental caries and periodontal disease
            b. ill-fitting prostheses, which may be discarded
2. manic episodes, which may involve overzealous use of toothbrushes and floss leading to 
   a. cervical abrasion 
   b. mucosal or gingival lacerations 
   b. the consequences to health generally of the impaired oral health 

2. takes account of the impact on the patient/client of the 
   a. phase of and type of episode currently experienced 
   b. influence of comorbidities 
   c. use of substances of abuse; heavy smoking 
   d. side-effects of medications, which may increase the severity of oral disease, such as dry mouth in both dentate and edentulous persons wearing complete dentures, and which may require attention to factors such as 
      i. avoidance of caffeinated and alcoholic drinks 
      ii. use of sugar-free candies and chewing gum to increase saliva flow 
      iii. use of fluoride gels or rinses 
      iv. use of chlorhexidine rinses 
      v. dysphagia, and difficulty chewing and speaking 
      vi. thrush 
      vii. fissuring at the corners of the mouth 
      viii. caution with medications that are habit-forming or addictive, such as benzodiazepines and opioid analgesics 
   e. counter-productive decision-making and behaviour 

3. works collaboratively with the family physician and other members of the clinical team, relative to pre-treatment information on 
   a. ability to provide consent 
   b. current health status and overall psychosocial profile 
   c. current medications and potential interactions 
   d. compliance with medications and treatment generally 
   e. recent or current in-patient care which, compared to outpatient care, may be associated with greater incidence of dental caries, periodontitis and subsequent tooth loss 
   f. likelihood of adverse reactions to the Procedures 
   g. likelihood of uncooperative behaviour for even minor oral healthcare 

4. supports the patient/client and the family caregiver 
   a. in matters of oral healthcare 
   b. by providing a care plan 

5. adjusts the duration and frequency of visits to 
   a. minimize stress 
   b. optimize preventive care, such as that addressed to persistent dry mouth 
   c. routinely monitor the soft tissues of the mouth 

6. communicates with the patient/client with techniques appropriate for 
   a. depression, including 
      i. speaking in a calm, quiet voice 
      ii. focusing on one subject at a time to allow for difficulties in concentration 
      iii. exercising patience and waiting to allow time for responses 
      iv. listening; the patient/client may benefit from knowing that what s/he said was heard even if a solution could not be offered
v. slowing down communication
vi. adopting a low-key approach that
   1. is non-judgmental
   2. does not overly stress
      a. the importance of choices or actions
      b. actions or problems needing future attention
vii. avoiding
   1. in-depth interrogation of the person about the depression and
      provoking factors
   2. offering suggestions for dealing with depression
viii. self-pacing; the professional interaction with the depressed
     patient/client may be exhausting for both parties
b. mania and hypomania, including
   i. reducing stimuli to avoid overstimulation, a susceptibility in hypomania
   ii. keeping conversations brief
   iii. dealing only with immediate matters
   iv. avoiding reasoning and argument
   v. discouraging discussion of feelings
   vi. avoiding authoritative stances while being firm, practical and realistic
   vii. avoiding the appearance of jumping to the person’s demands
   viii. avoiding getting caught up with the person’s euphoria, or unrealistic
        expectations
   ix. refraining from attempts to convince the person that his or her plans
       are unrealistic, while ensuring his or her safety.

MEDICATIONS SUMMARY

Sourcing medications information

1. Adverse effect database
   - Health Canada’s Marketed Health Products Directorate
toll-free 1-866-234-2345
   - Health Canada’s Drug Product Database

2. Specialized organizations
   - US National Library of Medicine and the National Institutes of Health Medline Plus
Drug Information
   - WebMD

3. Medications considerations
   All medications have potential side effects whether taken alone or in combination with
other prescription medications, or as over-the-counter (OTC) or herbal medications.

4. Information on herbals and supplements
   - US National Library of Medicine and the National Institutes of Health Medline Plus
Drug Information All Herbs and Supplements

5. Complementary and alternative medicine
   - National Center for Complementary and Integrative Health
Types of medications

Medications
1. mood-stabilizers
   - lithium (Eskalith®, Lithobid®)
   - carbamazepine (also an anticonvulsant; Carbatrol®, Epitol®, Equetro®, Tegretol®)
   - lamotrigine (also an anticonvulsant; Lamictal®)
   - valproic acid (also an anticonvulsant; Depakene®, Depakote®, Stavzor®)
2. antidepressants
   - amitriptyline (Elavil®)
   - fluoxetine (Prozac®)
   - imipramine (Tofranil®)
3. anti-anxiety medications
   - clonazepam (Rivotril®)
   - lorazepam (Ativan®)
4. antipsychotics
   - clozapine (Clozaril®)
   - olanzapine (Zyprexa®)
   - quetiapine (Seroquel®)
   - risperidone (Risperdal®)

Side effects of medications
See links above for side effects of specific medications.

THE MEDICAL AND MEDICATIONS HISTORY

The dental hygienist in taking the medical and medications history-taking should

1. try to overcome reluctance on the part of the patient/client to disclose a history of bipolar disorder by
   a. using appropriate techniques of communication
   b. reassuring the patient/client that the information is necessary for the provision of safe oral health, especially relative to
      i. contraindications
      ii. obtaining advice from the appropriate primary care provider(s)
   c. reassuring the patient/client that the information will be kept confidential
2. focus on screening the patient/client prior to treatment decision relative to
   a. key symptoms
   b. medications considerations
   c. contraindications
   d. complications
   e. comorbidities
   f. associated conditions
3. explore the need for advice from the primary or specialized care provider(s)
4. inquire about
   a. pointers in the history of significance to bipolar disorder, such as a history of problems with oral healthcare or minor surgery

2 Less common, and sometimes off-label, is use of the anticonvulsants gabapentin (Neuroatim®) and topiramate (Topamax®).
b. the current phase of the patient/client’s episodes because the manic phase or depressive phase may indicate the need for physician advice
c. the patient/client’s understanding and acceptance of the need for oral healthcare
d. medications considerations, including over-the-counter medications, herbals and supplements
e. problems with infections generally and specifically associated with dental/dental hygiene care
f. the patient/client’s current state of health
g. how the patient/client’s current symptoms relate to
   i. oral health
   ii. health generally
h. recent changes in the patient/client’s condition.

IDENTIFYING AND CONTACTING THE MOST APPROPRIATE HEALTHCARE PROVIDER(S) FOR ADVICE

Identifying and contacting the most appropriate healthcare provider(s) from whom to obtain medical or other advice pertinent to a particular patient/client

The dental hygienist should
1. record the name of the physician/primary care provider most closely associated with the patient/client’s healthcare, and the telephone number
2. obtain from the patient/client or parent/guardian written, informed consent to contact the identified physician/primary healthcare provider
3. use a consent/medical consultation form, and be prepared to fax the form to the provider
4. include on the form a standardized statement of the Procedures proposed, with a request for advice on proceeding or not at the particular time, and any precautions to be observed.

UNDERSTANDING AND TAKING APPROPRIATE PRECAUTIONS

Infection Control

Dental hygienists are required to keep their practices current with infection control policies and procedures, especially in relation to

1. the CDHO’s Infection Prevention and Control Guidelines (2019)
2. relevant occupational health and safety legislative requirements
3. relevant public health legislative requirements
4. best practices or other protocols specific to the medical condition of the patient/client.

DECIDING WHEN AND WHEN NOT TO INITIATE THE PROCEDURES PROPOSED

1. There is no contraindication to the Procedures unless the patient/client displays manic, catatonic, or psychotic signs/symptoms that pose a risk to himself/herself or the dental hygienist (e.g., pronounced distractibility, psychomotor agitation, or disorganized behaviour).
2. With an otherwise healthy patient/client whose episodes are under control, who is in the well phase and whose symptomatic treatment is proceeding normally, the dental
Hygienist should implement the Procedures, though these may be postponed pending medical advice, which may be required if the patient/client has

- symptoms or signs of a manic or depressive episode of bipolar disorder
- comorbidity, complication or an associated condition of bipolar disorder
- possible immunosuppression or thrombocytopenia associated with mood-stabilizer or antipsychotic use (rare in the dental hygiene office setting)
- not recently or ever sought and received medical advice relative to oral healthcare procedures
- recently changed significant medications, under medical advice or otherwise
- recently experienced changes in his/her medical condition such as medication or other side effects of treatment
- is deeply concerned about any aspect of his or her medical condition.

DEALING WITH ANY ADVERSE EVENTS ARISING DURING THE PROCEDURES

Dental hygienists are required to initiate emergency protocols as required by the College of Dental Hygienists of Ontario’s Standards of Practice, and as appropriate for the condition of the patient/client.

First-aid provisions and responses as required for current certification in first aid.

RECORD KEEPING

Subject to Ontario Regulation 9/08 Part III.1, Records, in particular S 12.1 (1) and (2) for a patient/client with a history of bipolar disorder, the dental hygienist should specifically record

1. a summary of the medical and medications history
2. any advice received from the physician/primary care provider relative to the patient/client’s condition
3. the decision made by the dental hygienist, with reasons
4. compliance with the precautions required
5. all Procedure(s) used
6. any advice given to the patient/client.

ADVISING THE PATIENT/CLIENT

The dental hygienists should

1. urge the patient/client to alert any healthcare professional who proposes any intervention or test
   a. that he or she has a history of bipolar disorder
   b. to the medications he or she is taking
2. should discuss, as appropriate
   a. the importance of the patient/client’s
      i. self-checking the mouth regularly for new signs or symptoms
      ii. reporting to the appropriate healthcare provider any changes in the mouth
      iii. scheduling and duration of appointments to minimize stress and to take account of the patient/client’s current psychosocial profile.
   b. comfort level during appointment
c. stress and anxiety related to the Procedures  
d. mouth ulcers, altered taste and other conditions of the mouth relating to bipolar disorder, comorbidities, medications or diet  
e. the need for regular oral health examinations and preventive oral healthcare  
f. oral self-care including information about  
   i. choice of toothpaste  
   ii. tooth-brushing techniques and related devices  
   iii. dental flossing  
   iv. mouth rinses  
   v. management of a dry mouth  
g. the importance of an appropriate diet in the maintenance of oral health  
h. medication side effects such as dry mouth, and recommend treatment  
i. mouth ulcers and other conditions of the mouth relating to bipolar disorder, comorbidities, complications or associated conditions, medications or diet  
j. pain management.

### BENEFITS/HARMS OF IMPLEMENTING THE RECOMMENDATIONS

#### POTENTIAL BENEFITS

1. Promoting health through oral hygiene for persons who have bipolar disorder.  
2. Reducing the adverse effects, such as stress, by  
   a. taking account of the phase of episodes and the symptoms  
   b. generally increasing the comfort level of persons in the course of dental hygiene interventions  
   c. using appropriate techniques of communication  
   d. providing advice on scheduling and duration of appointments.  
3. Reducing the risk that oral health needs are unmet.

#### POTENTIAL HARMs

1. Exacerbating depression by taking insufficient account of the patient/client’s feelings of self-worth and mood.  
2. Performing the Procedures at an inappropriate time, such as  
   a. when the patient/client’s bipolar disorder is in the manic or depressive phase  
   b. in the presence of complications for which prior medical advice is required  
   c. in the presence of acute oral infection without prior medical advice.  
3. Disturbing the normal dietary and medications routine of a person with bipolar disorder.  
4. Inappropriate management of pain or medication.

### CONTRAINDICATIONS

#### CONTRAINDICATIONS IN REGULATIONS

Identified in the *Dental Hygiene Act, 1991 – O. Reg. 218/94 Part III*

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<tr>
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