GOALS FOR THE PERIODONTAL PATIENT

Principles for Non-Surgical Periodontal Therapy

- Sustained Disease Remission
  - Absence of Pathogens
  - Clinical Signs

- Modification of Risk Factors
  - Smoking
  - Diabetes
  - Nutrition

- Complete Debridement Site by Site
  - Healing
  - Abscess

- Reduce Bacterial Load
GOALS FOR THE PERIODONTAL PATIENT

Goals for the Periodontal Patient:

1. Modify Risk Factors
   a. Overall goal is total health.
   b. Research shows that oral health is related to total health
   c. #1 preventable risk fact is tobacco use
   d. Other systemic diseases related to increased risk for periodontal disease are
      i. Diabetes
      ii. Rheumatoid Arthritis
      iii. Heart Disease
      iv. Stroke
      v. High Cholesterol
      vi. Pregnancy
      vii. Poor Nutrition
      viii. The list continues...
      Continue to check updates at www.perio.org and www.pubmed.com

2. Complete Site–by–Site Debridement
   • If you have a patient with 5-6mm pocket depths in all four quadrants (more than 1-3 teeth in each quadrant) you will schedule the patient for 4-1 hour appointments for scaling and root planing. (PT, SRP, Periodontal Therapy)
   • For example, the patient will return for URQ and the 2nd appointment is for LRQ. When the patient returns for quadrant # 2 you will use ultrasonics and gently debride quadrant #1. (retreat previous area. Repeat this procedure for all future PT appointments) The goal of periodontal therapy is to remove bacteria and biofilm that has reoccurred in each quadrant that has previously been scaled. This is not meant to disrupt the process of epithelial attachment but to remove biofilm that has reoccurred in the sulcus.

3. Reduce Bacterial Load
   • Reduction of the bacterial load can ‘sometimes’ be accomplished by using lasers (This article uses an example of some research: http://bit.ly/1aD4HYk) and/or removal of biofilm by scaling, home care techniques, use of Arestin®/Atridox, Actisite® fiber, etc.
4. Sustained Release Remission
   - What are the clinical signs to show remission? Is there BOP?
     Is there a reduction in pocket depth? What else clinically shows signs of remission?

When you know that all of these goals are accomplished you will determine the patients **end-point balance.**

**End-Point Balance**

*Scaling and root planing is not the “end-point for therapy.”*

End-point balance refers to the amount of time a patient can go between SPT appointments (After SRP –Phase I Therapy is complete) without showing clinical and especially radiographic signs of disease.

For example, if you have a patient that is a tobacco user, when they return after Phase I Therapy, it is very likely that a 6mm pocket will at best become 5mms. It is in the best interest of this patient to return for more PT (SRP) and even Arestin®, Atridox, or Actisite® fiber, etc.

Recommended in this scenario if more PT (SRP) and finally a 4-6 week re-evaluation. (SPT - Periodontal Maintenance Appointment.) At this point, if pocket depths are not decreased to 4 or 5mms, you may want to begin SPT (Periodontal Maintenance) at 2 month intervals. When the patient is able to demonstrate that they can remain stable at 2 months you may consider a 3 month interval for the SPT.

**Five Point Clinical Philosophy of Dental Practice Solutions**

1. Individualized Treatment Plans
2. Open-ended Treatment Plans
3. Repetitive Therapy
4. All Encompassing Therapy
5. Closely Monitored System
GOALS FOR THE PERIODONTAL PATIENT

What does this mean for you?

1. Treatment plans are individualized using each patient’s individualized specific needs and risk factors, to create a customized treatment plan blending restorative care into their therapy.

2. Treatment plans for the periodontal patient are open ended; meaning that we estimate the number of visits needed to allow complete healing and disease remission not just smooth roots.

“Periodontal Treatment – Phase I Therapy is not the end point.”

3. The concept of repetitive therapy allows us to revisit areas as many times as needed to achieve wood healing.

4. Using all encompassing therapy you will utilize any technology and therapy within the scope of your practice to assist the patient in achieving remission, with emphasis on the blended treatment plan.

5. With a closely monitored system, we customize the intervals between periodontal maintenance appointments to support the patient in maintaining disease remission. This means that occasionally a patient who completes Phase I Therapy may not stay in remission but may experience bleeding on probing and pockets that change from 4mms to 5mms or more. (Occasionally the scenario of periodontal disease is called “episodic” for this reason) Possibly 4 and 5mm pockets will return to 6mms or higher. This especially happens when patients choose to not return in a timely manner for the Supportive Therapy Hygiene Appointments. For many patients they may remain stable at 5mms. For other patients this may mean that you need to refer to a periodontist. It really depends upon their risk factors. Remember, treatment for the periodontal patient is

Risk assessment is the driving force behind periodontal treatment planning according to the American Academy of Periodontology as reflected in their 2005 Academy report guidelines on management of patients with periodontal diseases. (Read the report: http://bit.ly/17cSd44)
Patients who are diabetic for example, will not heal as well as healthy individuals and their diabetes will make them more prone to infections.

When treating pregnant patients, your care impacts the developing fetus as well. The hormonal changes of pregnancy, menopause and sometimes even menstrual cycles will cause the patient to be more susceptible to bacterial infection.

Those with cardiovascular disease are at greater risk due to the inflammatory nature of both periodontal and heart disease. Patients with genetic susceptibility or an exaggerated immune response will be more challenging to treat. Patients with cancer or chronic inflammatory diseases such as rheumatoid arthritis, or lupus also have risk factors complicating or interfering with their ability to heal.

A very common risk factor in the western world today is poor nutrition despite the abundance of good foods available to most of your patients today. With a poor level of nutrition it is very difficult to expect the best outcome of treatment. As our understanding of periodontal disease evolves we now have the technology to identify the pathogens causing periodontal infections.

This knowledge changes our treatment options.

How Has Treatment Planning Changed Over the Years?

Originally when many of us were educated in school, we based our treatment plan on the pocket depths. Often we were not offering more than a flossing lecture although our patient’s pockets were quite deep.

Then we would look at the amounts of calculus to indicate a need for root planing. Next we would look at the bleeding but not too much because after all everybody bleeds. RIGHT?

WRONG!

Then if the patient had less than perfect homecare we could blame this for their periodontal condition. But no matter what disease they presented with if their insurance was maxed out or non-existent, the clinician might be reluctant to broach the subject at all and just give the patient a really good cleaning and give that “flossing lecture.” YIKES!
With the current criteria being about science we will look at bleeding first. Healthy gums do not bleed. Bleeding is an indication of a bacterial infection. The level of bleeding will indicate the amount of therapy a patient may need.

The level of bleeding is assessed during probing and tissue response which is gentle instrumentation with a periodontal probe. Does your patient exhibit loss of attachment?

What other risk factors do your patient’s have? What are the patient’s restorative needs and do they have an impact on their periodontal health?

Once your patient has completed treatment how long can they go between maintenance appointments and remain in remission? This is the patient’s balance point. How much plaque and calculus is present? Now we need to look at pocket depths, radiographic areas of bone loss and patient compliance.

Notice that insurance is not a part of our criteria. Let’s ask ourselves, “How much bleeding is ok?” In your own mouth are you able to accept a little bit of infection? How much disease is acceptable to you? Is a little bacterial infestation ok with you?

The bacteria will take a ride into the body via the blood vessels triggering a cascading series of events linked with other diseases. Now ask yourself again, “How much bleeding is ok?”

*I hope you answered that it is not ok to have bleeding anywhere in your body, especially your mouth.*

The pie chart you have received (A few days ago) indicates proportions of hygiene procedures preformed as your dental practices philosophy of early and complete periodontal disease evolves.

As the evolution of periodontal philosophy occurs we see more patients actively treated for periodontal disease and your proportions in those pie charts will change until ultimately on the fourth pie chart you can see that the amount is only approximately 17% of your adult patient base is receiving a routine prophylaxis. The rest of your adult patients are in active therapy (PT or SRP) or supportive periodontal maintenance. This more accurately reflects the prevalence of
periodontal disease in the US according to the ADA, AAP and the surgeon general. Here is how we transition a patient from routine preventive care (D1110) into active therapy. When a patient comes in for a routine preventive appt or periodontal maintenance, if the patient’s periodontal status is unhealthy, the classification of the appointment changes and is called an initial diagnostic therapy or **IDT**.

This includes 5 screenings to assess the pts level of disease and risk factors including a detailed health screening.

You will assess: Health History, a BP screening, Antioxidant Screening and Nutrition, an OCE, a restorative screening and a full-mouth perio screening. (Six-point perio screening needs to be completed annually and *always* spot probe before a curette is used for scaling during a hygiene appointment of any type)

I recommend that you alternate some of these above mentioned assessments so they are done at the appropriate intervals and for example a full mouth periodontal screening exam can be coordinated to alternate when radiographs are necessary. Same with the Smile Evaluation and the Oral Cancer Screening Technology, provided for your patients of record annually.

After the screenings are conducted the hygienist will sit the patient up in the dental chair and do an initial case presentation of his or her findings. This is when they will address the patient’s oral conditions, any questions, education patient on oral hygiene (homecare) and co-therapy instructions are given at this time. (Discuss what you “See” or what is present in their mouth. Have the patient “see” this with you using a hand mirror and intra-oral camera.)

Case presentation for the periodontal patient is followed by the clinical procedure for the removal of supragingival deposits, polishing and subgingival biofilm destruction. This will jump start the patients immune system.

The doctor will come into the treatment room (Refer to Day 16 “Down to a Science”) to complete an exam, the pt receives great value in their hygiene apt and they are educated about their need for further treatment.
When your patient is 1st diagnosed with periodontal disease the patient will schedule their 1st periodontal therapy appointment. This will be the 1st of possibly 1-6 appointments PLUS a re-evaluation 4-6 weeks post Periodontal Therapy. Usually the treatment coordinator or another auxiliary will schedule the series of PT or SRP appointments, not the hygienist in the treatment room. Future routine SPT or Preventive Care appointments should be the hygienist or hygiene assistant that will schedule these types of appointments. More about this in a few days.

The re-evaluation will be your next appointment after the Periodontal Therapy is complete. The re-evaluation is similar to a post-op appointment. This is usually scheduled 4-6 weeks after SRP (PT) has been completed.

The re-evaluation (1st time after SRP that you bill as a Periodontal Maintenance Appointment – SPT) is where you will discover if they need more therapy or can advance to SPT appointments. You may need to retreat any areas that are not considered in remission before you advance this patient into SPT appointments. (Remission meaning that there is pocket depths of 5mms or less and no BOP.) Remember that treatment planning for the patient with periodontal disease needs to be open ended.

Let’s look at a possible treatment plan for early disease or gingivitis. That would include an initial diagnostic therapy. (IDT) The pt is presented with 2-4 gingivitis therapy appts, how much treatment they need depends upon how they heal. We can not predict this. We will observe and evaluate their healing throughout their treatments. Four to six weeks later you will re-evaluate their status.

Begin to use terms with your patients such as “Preventive Care Appointment,” (Preventive Care) “Supportive Periodontal Therapy,” (SPT) Initial Periodontal Therapy, (IDT) and Gingivitis Therapy. (GT)

These words, these acronyms, describe exactly what we are doing at the each appointment, rather than saying to your patient the words: “Continuing Care,” “Recare,” “Recall,” or “Deep Cleaning.” This really does add value to the dental hygiene appointment. Watch and even monitor how many less short-notice cancellations you will have when you change the words you use with your patients.
Recall reminds me of a car problem where you take your car to the dealer for a repair.

Remember that by treating at the earliest stages we are preventing loss of bone or permanent damage. And we are reducing the incidence of other inflammatory diseases such as rheumatoid arthritis.
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TREATMENT PLANNING CASE STUDY
Intraoral Camera Photo Taken

Taken with Intraoral Camera
Robby is a 24 yr old Asian male. He is not taking any medications and has no health concerns. His chief complaint is that he wants whiter teeth. When reviewing the medical history the hygienist discovered that he has Xerostomia and that he is a mouth breather, especially at night, since he reports waking up with a dry mouth. He has not seen a dentist since he was 18 yrs old.

Robby had an oral cancer exam with the Oral ID® and the screening was negative. The hygienist completed a full-mouth periodontal screening exam.

Robby has generalized 1mm’s of recession with 4mm pocket depths generalized in the posterior areas as well as localized areas in the upper maxillary areas #7-10. (Maxillary lateral to later areas.)

His gingiva is slightly red along the margins of his maxillary anterior area. He has slight to moderate inflamed interdental papilla generalized, especially in the anterior areas. There is generalized bleeding upon probing.
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Complete the following

Patient Chief Complaint:


Treatment Plan:

Homecare Recommendations:

Is patient open to accepting treatment? Yes No

If “NO” can you explain the patient’s obstacles and/or objections for accepting treatment? What is their chief objective to accepting treatment?

(Your explanation to overcome their chief objective will be the opposite of their challenge, chief objective)

Example: If the patient doesn’t have the money to pay for treatment you will talk about the cost of implants or dentures. What is the cost if the patient decides to do nothing? This is what you will talk about.

If time off of work is an issue; do you offer weekend appointments, early morning, lunch hour or evening appointments? Explain how much time will be spent in the dental office if the patient waits to do more treatment. (More extensive with time and money.)

Understand how this person will make decisions. Do they speak slowly? Do you believe they are a person who needs a lot of information? We will discuss case acceptance in a few days but it is helpful if you can begin to imagine how this person thinks. What makes them tick? What do you know about them? Do they trust you?
TEAM BREAK OUT SESSION

Have your office break into groups and create a treatment plan for this patient. If you have more than 1 hygienist, have each hygienist work with other team members. Have doctor be on a different team than the hygienist. (s)

Come back together as a team and discuss your answers. Come to an agreement for your office protocol for this type of patient.

Pick 2 more patients to discuss re: treatment planning. It may benefit your team to choose a patient that has Moderate Perio and another patient who has Advanced Perio so everyone on the team and especially the hygienists, can all agree to the same treatment recommendations.

Should you want to go deeper into treatment planning please call our office to schedule a no-fee consultation.

888-816-1511 or email our team: support@dentalpracticesolutions.com

You are also given 1-30 min consultation with Debbie at no additional cost. Please schedule this if you have not completed this.