

The Brown

PerioDontaLetter



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From Our Office to Yours...

The key to success in periodontal therapy is early diagnosis and treatment intervention.

*This current issue of **The PerioDontaLetter** addresses the question of how best to manage periodontal disease in the general practice, if "watchful waiting" is a desirable option to active periodontal therapy, when to consider referral, ways to maximize the patient's receptiveness to additional treatment, and making referrals as effective as possible.*

As always, we welcome your comments and suggestions in our continuing efforts to provide our mutual patients the best periodontal care possible.

Managing the Periodontal Patient -- The Team Concept

Successful, periodontal treatment maximizes the comfort, health, appearance, function and longevity of the natural dentition. Ideal success includes the absence of periodontal pockets, meticulous plaque control, regeneration of periodontal defects, esthetic appeal, and stable functioning teeth.

Periodontal disease is a chronic, long-term, and intermit-

tently aggressive infection. A specific microenvironment is required for the pathogens to create the disease process. The periodontal pocket provides such an environment, and therefore plays a pivotal role in supporting the colonization of bacterial pathogens and altering the host response in favor of periodontal disease.



Figures 1 and 2. Scaling and root planing improved the inflammation of the gingiva and the tissues appear healthy to the naked eye. (See Figures 3 and 4.)

Research has shown patients demonstrating pockets of 6mm or greater are the most likely to experience continued loss of attachment. Schatzle et al (2003) in a 26-year study of attachment loss reported the age group experiencing the greatest rate and mean annualized risk of attachment loss was between 16 and 34 years of age. In an earlier study, this group of investigators found that risk for progression also increased in individuals over 40 years old. Patients with persistent inflammation were 70% more likely to experience attachment loss. A paper by Mao-Chi (2000), as well as several earlier published studies, demonstrates that reduction of periodontal microbial flora is more effective following pocket elimination than it is after open flap debridement without pocket elimination.

These reviews suggest that the process of “watchful waiting” could be a disservice to our patients and needs to be modified as follows:

- Posterior areas and mandibular anterior sites need to be viewed

more critically, emphasizing surgical pocket elimination rather than other treatment modalities.

- Attachment loss in young to middle-aged patients needs to be treated aggressively.

- Early surgical intervention is more likely to control the progression of chronically inflamed sites, than delay or non-surgical treatments.

- Shorter recall intervals are recommended for patients with widespread, persistent, gingival inflammation.

- Patients exhibiting sites with pockets in excess of 6 mm or greater are not candidates for preventive maintenance alone.

Which brings us to the question: When should a patient be referred?

Initial Periodontal Therapy in the General Practice

A quality periodontal program requires coordinated efforts between the patient, general dentist, hygienist and the periodontist.

It is important that the periodontal program include periodontal examinations on all patients, documentation of clinical findings, continued assessment of the patient’s periodontal status and that patients are aware of their current situation and recommended treatment needs.

The benefits of a soft tissue management program are generally well-known and include:

- Helping patients to reduce or eliminate existing periodontal disease

- Building rapport with new patients

- Building the patient’s confidence in the restorative dentist’s diagnosis and treatment planning

- Exhibiting quality care, enhancing patient education, informing patients of their periodontal status, satisfying legal requirements

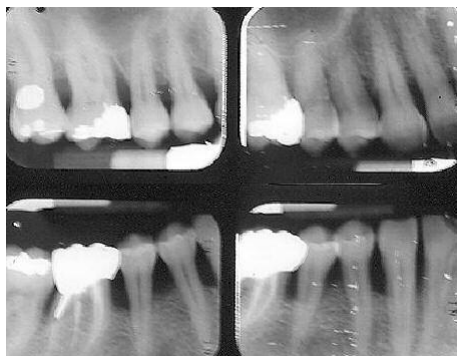
- Maintaining periodontal stability

- Determining which patients need to be referred to the Periodontist

- Improving the predictability of restorative care by creating a better environment in which to perform restorative dentistry

Good clinical records and documentation are very important. Complete records provide for accurate diagnosis and the development of an appropriate treatment plan. Good records offer an objective means of monitoring the success of treatment or the progress of disease. Thorough records are the best way to minimize liability risks and they are routinely requested for processing insurance claims.

The suggested documentation required for a periodontal examination includes a thorough medical and dental history as well as identifying



Figures 3 and 4. Radiographs, however, reveal very significant osseous defects which were masked by the clinical appearance of the gingiva. (See Figures 1 and 2.)

the patient's chief concern. A comprehensive periodontal exam includes the following recordings:

- Oral hygiene status
- Charting of pocket depths
- Presence of gingival bleeding and exudate
- Tooth mobility
- The presence or lack of attached gingiva
- The presence and amount of gingival recession
- Parafunctional habits and occlusal discrepancies
- Radiographic examination – full mouth periapical x-rays as needed based on the clinical examination

Following the examination, the clinician processes the examination findings, determines a diagnosis and treatment plan and makes the decision to treat the problems in the general dentist's office or to refer to a periodontist for necessary treatment.

In general, the restorative practice has three distinct treatment sequences for periodontal therapy:

- 1) Examination > general dentist provides treatment > reevaluation > maintenance and monitoring
- 2) Examination > general dentist provides treatment > reevaluation > referral to periodontist > maintenance and monitoring
- 3) Examination > referral to periodontist > maintenance and monitoring

Upon completion of soft tissue management, the patient needs to receive a thorough reevaluation to assess the results of the treatment provided. The recommended time frame for this reevaluation is approximately four weeks following the last visit for scaling and

root planing. At one month, the clinician is able to evaluate the response of the soft tissues and make an accurate determination of the need for more comprehensive periodontal therapy.

Patient reevaluation examinations should include assessments similar to the initial exam, including recordings of oral hygiene status, reprobing and charting of pocket depths, gingival bleeding, mucogingival defects and recession, mobility, and radiographic bone levels. Such documentation will facilitate decisions regarding the appropriateness of a referral to a periodontist or continuation with routine maintenance.

From a practice management standpoint, it is helpful to inform patients that initial therapy is often not the end-point of periodontal therapy, but rather an opportunity to evaluate outcomes and make further treatment recommendations. Therefore, before scaling and root planing is initiated, it is important the patient understand that referral to a periodontist may be necessary depending on the tissue's response to this therapy.



Figure 5. Following scaling and root planing, the gingival tissues appear healthy.

When to Consider Referral

We are often asked when a patient should be referred for periodontal treatment. The sharing of ideas, alternative approaches to treatment, and collective responsibility, generally results in the best treatment for an individual patient.

Treatment of patients with medically-compromised status, or those having severe osseous defects, are best served by initiating treatment with a periodontal specialist. When initial findings include questionable teeth, extensive occlusal or restorative needs, assistance in the development of a treatment plan by a periodontist may be helpful. When extensive restorative treatment is anticipated and an assessment of strategic abutment teeth is required, referral to a periodontist is an excellent option. Referral may also be indicated for patients manifesting refractory periodontitis, juvenile periodontitis or rapidly progressive periodontitis.

The management of the referral process is an extremely important aspect to providing treatment excel-

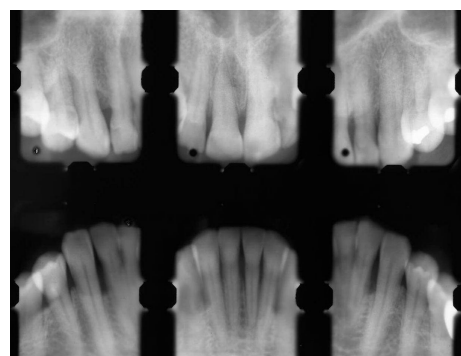


Figure 6. The rest of the story is revealed in radiographs which evidence moderate to severe bone loss.

lence and predictable results. Brit Beemer, a South Carolina marketing consultant, studied the referral process in dentistry, and constructed a “referral ladder,” outlining the critical steps necessary to ensure a favorable outcome. To gather accurate data, he conducted “exit polls,” interviewing patients who had been referred to specialists.

The referral process begins with the referring doctor’s credibility in the eyes of the patient. It cannot be successful if the referring doctor has not established credibility and trust. The longer the relationship with a patient, the more likely we can convey sincere confidence that referral to a specialist is the best treatment option.

The second and third steps address the fears created when a specialist referral is suggested. Patients often believe that the cost of specialty care is beyond their means. Additionally, when patients are told

that treatment by a specialist could involve surgical care, it produces anxiety. Consideration of a surgical procedure may subconsciously imply a life threatening event.

It is helpful for the patient to understand that reestablishing and maintaining health are significantly less costly than continued disease. Furthermore, delays generally result in more complicated and more expensive treatment plans. Reassurance that modern periodontal procedures are extremely well-controlled relative to safety and comfort is important. Beemer suggests that the referring dentist and the specialist take steps to address these fears.

Such high level communication requires a commitment of time and sensitivity to the patient’s felt needs and concerns. This usually cannot be done at a hygiene examination when time is not available. We recommend that specific time be set aside for an open discussion of the referral process. When referral recommendations are made in a safe environment of care and concern, most patients will be open to and appreciative of seeing a specialist.

The Most Important Step -- Communication

According to Beemer, the most important step in the entire referral process is who makes the appointment for the patient. His findings indicate that when the referring doctor or one of his staff calls the specialist’s office directly and arranges the appointment, patients honored

their scheduled time and almost always completed the recommended treatment. By making such efforts on behalf of the patient, the importance of seeing the specialist is exponentially magnified. It is a true expression to patients that their dentist cares about them and is serious about the importance of the referral.

From an administrative point of view, assisting the patient to make the appointment helps insure that the patient does not get lost in the referral process. Similarly, it provides the specialist’s office with enough information to track the patient and to notify you directly if a cancellation or some other failure in the process takes place. This substantially helps the patient in getting the treatment he or she requires in an expedient manner.

The second most important aspect of the referral process is the quality of communication between the referring office and the periodontal office regarding the specific needs of each patient. It is very common for patients to inquire of the specialist if their general dentist and the specialist have consulted with each other or if pertinent records have been exchanged. It reinforces the referral when the patient is convinced that the two doctors involved are speaking with “one voice.”

We consistently remind ourselves of our commitment to a high level of communication. We promise to do whatever it takes to fulfill our commitments to your office and your patients.

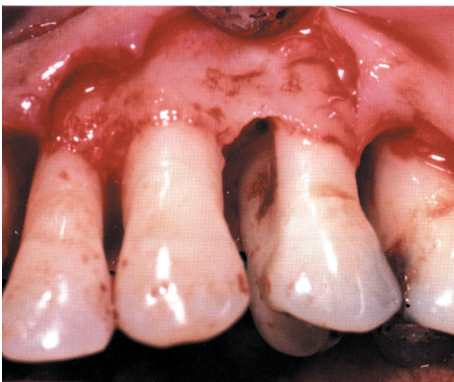


Figure 7. Surgical exposure reveals calculus remaining in the mesial root concavity of the upper first premolar which was inaccessible with presurgical hand instrumentation.

