The Brown

PerioDontaLetter

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From Our Office to Yours...

During the 1980's, dental practices underwent a "soft tissue management" revolution. General practices across the country reexamined the process of treating periodontal disease by controlling plaque-induced gingival inflammation. A strong emphasis was placed on systematic root planing enhanced by the use of powered toothbrushes and other aids.

Practices discovered through more frequent screening and periodontal examinations that a significant percentage of their patients were prime candidates for these services.

This newsletter will address what we believe are the keys to an effective soft tissue management program to help insulate your practice from the invasive control of third party payers.

As always, we welcome your comments and suggestions in providing excellent periodontal care to your patients and attracting and stimulating practice growth.

Successful Soft Tissue Management

In most practices, the hygiene department is often the first experience with active treatment for many patients. With attention to detail, the patient's perception of the quality of care in a practice can be greatly enhanced by the quality of this experience. The key to the patient's perception of value is to clearly distinguish soft tissue management from traditional cleanings.

The perception of quality must permeate the initial contact with the office. This includes a thorough review of the patient's medical and dental history and an assessment of the patient's chief concerns, including their expectations and limitations. The examination should be a fact finding mission and an exercise in "guided discovery" with the patient. An ideal situation would be to tell the

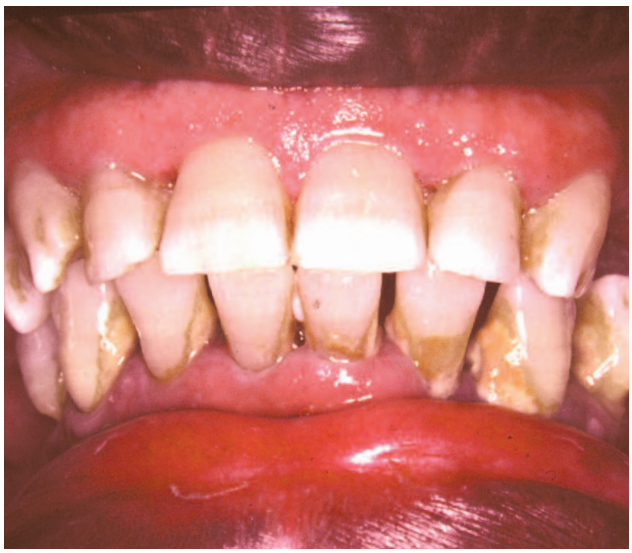

Figure 1. Examination prior to the initiation of scaling and root planing exhibits severe gingival inflammation as a result of the heavy accumulation of plaque and calculus.

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patient what is going to be done and provide an explanation of the findings, i.e. pocket probing depths, mobility, radiographic findings, etc. We strongly recommend that all new patients have a current full mouth series of radiographs and be examined by the dentist prior to initiating therapy by the hygienist.

It is extremely powerful to emphasize that periodontal disease is an **infection** which may be readily managed with available treatment programs. Calling attention to the data that this infection has been proven to affect the human body in other ways, such as its link with cardiovascular disease, will further enhance the perception of value for undertaking treatment.

A systematic, detailed, written method of documentation, periodontal examination and charting, is essential to meeting outside agency challenges to treatment recommendations and is essential to satisfy the current standards of care. As the doctor makes a "tour" of the mouth, he/she should communicate the findings so they may be recorded.

Another "value-added" service we recommend is an oral cancer screening exam which should conclude with a statement confirming the findings even if they are negative. An assessment of the status of occlusion and TMJ would also be a valuable adjunct. Articulated study models should be obtained if there is a suggestion that restorative dentistry, orthodontics or other adjunctive procedures will be considered in formulating an adequate diagnosis and treatment plan. Upon completion of the periodontal examination, a diagnosis should be made and patients placed in one of the five American Academy of Periodontology categories.

We recommend that the treatment plan and sequence be presented at a second "conference for treatment planning." Telling the patient that additional time will be spent to assess the clinical data to permit a detailed explanation of what has been found, what should be done, how long it will take, and what it will cost further enhances the perception of value for the initial examination. The hiatus between the two visits, which should be scheduled closely together, provides the patient with time to process what they have seen and heard. Invariably this allows more thoroughness.

The doctor sets the tone for the treatment conference by providing a thorough review of findings from the previous visit, including a brief explanation of the significance of observable radiographic findings. If study models have been obtained, a discussion of occlusion and related restorative issues sets the stage for the acceptance of future restorative treatment recommendations. It also permits a discussion of iatrogenic periodontal hazards, such as overhanging margins, open contacts, caries, defective restorations, etc. A treatment plan should be presented that is area specific and has a sequenced approach to controlling the disease activity which is evident.

Scheduling Soft Tissue Management

Allotting adequate time to complete soft tissue management in quadrants, or combined segments in the case of isolated involvement, gives the hygienist time to make inroads in patient understanding and personal preventive care. We recommend a sequence of visits at set intervals based on the level of disease activity and amount of deposits. Patient understanding of the disease process and the anticipated level of compliance should be factored into the scheduling process. Longer, more productive visits are preferable to shorter, more frequent ones.

Each treatment visit should strive to differentiate the process of "soft tissue management" from less-involved maintenance care to which most patients are accustomed. To make this form of periodontal care a value-added service, check this list of steps against your current methodology, so that you may set in motion an outstanding periodontal disease management program.

1. Before initiating scaling and root planing, it is critical that patients be informed that this initial therapy may

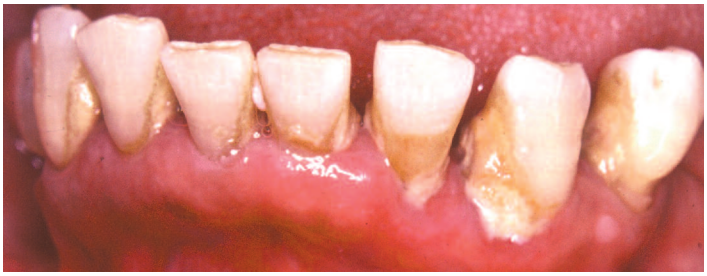

Figure 2. Greater magnification of the mandibular teeth and gingival tissues prior to scaling and root planing and plaque control.

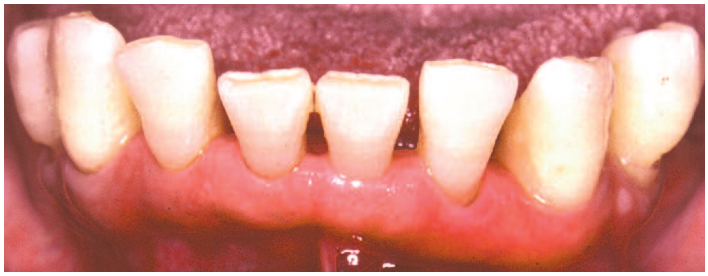

Figure 3. Following thorough debridement and removal of local irritants, the gingival tissues have a tremendous capacity to repair.

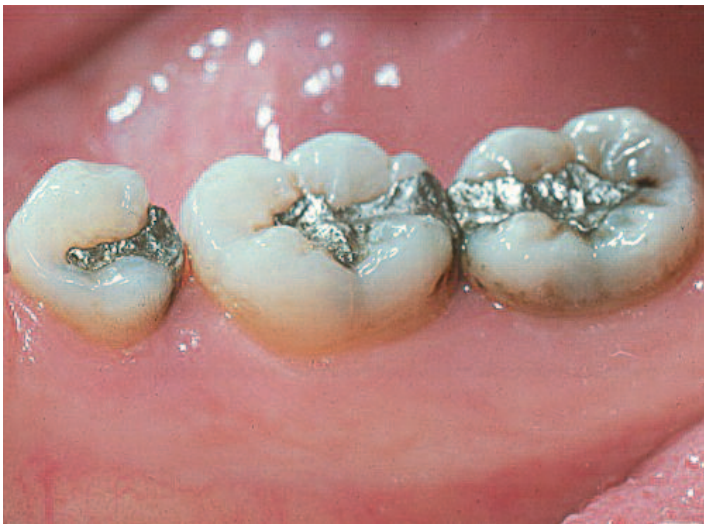

Figure 4. After scaling, root planing and antimicrobial therapy, the gingival tissues appear clinically healthy.

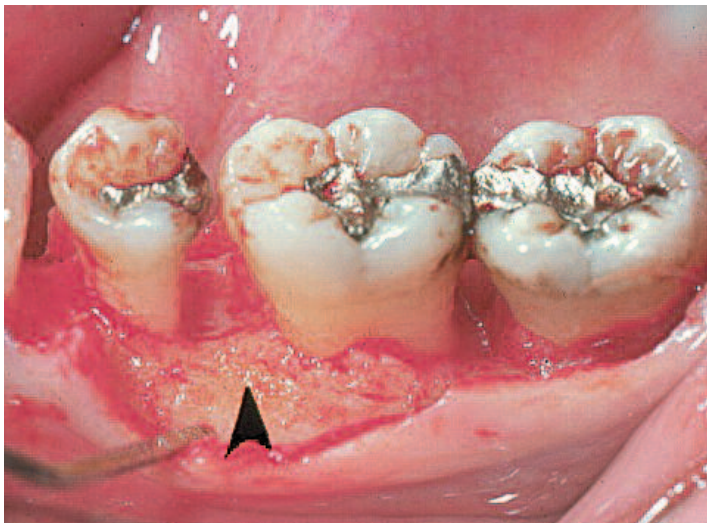

Figure 5. However, flap reflection in an area with pockets greater than 5mm in depth reveals significant reverse osseous architecture with intrabony defects.

not totally resolve their periodontal problems and needs. Following scaling and root planing, further treatment and or a referral to a periodontist may be necessary.

2. Focused oral hygiene instructions. Patients need to see their situation as unique. Oral hygiene instructions should be a discovery of the signs and symptoms of disease activity, not a brushing/flossing lesson. Help patients discover the at-risk sites in their mouths and assist them to co-discover techniques or hygiene instruments which will be appropriate and ones with which they can use.

Remember the "KISS" principle. Choose methods and devices which are time-efficient and easy to use. It's amazing how many patients will readily use a toothpick, but balk when dental floss is suggested. Be willing to experiment with new ideas.

Water-irrigating devices to deliver antibacterial agents to pathologic sites may be of benefit. Studies show that irrigation of an antimicrobial reaches subgingivally when a patient uses a pressure irrigator or when a clinician uses a syringe and cannula. However, the gingival crevicular fluid in a 5mm periodontal pocket may replace itself in 90 seconds. Anything placed in the pocket will be washed out in that period of time.

Identify those sites where full pocket shrinkage may not be achieved and acknowledge that more definitive pocket reduction procedures may be necessary in the future.

3. Soft Tissue Management is sophisticated root surface treatment. Dr. Connie Drisko has described a methodology that may reduce scaling and root planing time by 40%. She recommends the use of local anesthesia, which helps to differentiate STM from routine "cleanings," reduces treatment time, eliminates patient discomfort and improves access to deeper pockets.

Begin by reducing heavy calculus and stain with a high power universal Cavitron tip. Switch to a 30K universal tip at a lower power to remove small deposits and to smooth roots. Repeated instrumentation from different angles will help reach bi- and tri-furcation areas and deep proximal defects. Lastly, finish irregular surfaces with well sharpened, delicate hand instruments. Consider starting patients on an NSAID or other appropriate analgesic and continuing for up to 48 hours. Patients will appreciate concern for their comfort and it will serve to enhance their perceived value for these services.

4. The success of soft tissue management is enhanced by controlling other contributing factors during the soft tissue management process. It is desirable to combine appointments for caries control and correction of restorations whose contacts, contours and margins are a contributing etiologic factor. This may be coupled with strategic extraction of hopeless teeth. Removing some or all of these will have a profound effect on creating an environment which favors health and which is easier for the patient to maintain.

5. Be realistic and assess the results from a biological perspective. Numerous studies have demonstrated that the average soft tissue shrinkage following root planing is 1.5mm depending upon the initial level of soft tissue thickness, inflammation and pocket depth. Only a

small percentage of pockets of 7mm or more can be reduced by 3mm or more. Minimum post-treatment documentation includes probing, analysis of recession and an assessment of the presence of bleeding on gentle probing and mucogingival defects.

6. Keep in mind soft tissue management is limited to the management of the inflamed gingival component of periodontitis. The underlying bone loss and bony defects are not affected or resolved by soft tissue procedures other than limited marginal tissue shrinkage. Soft tissue management, therefore, is not an end-therapy for patients with bone loss, especially vertical bone loss patterns. The standard of care, even for isolated problems, requires proper attention to these progressive periodontal defects, usually by pocket elimination surgery or regenerative therapy.

A key element in the proper soft tissue management program is a post-treatment evaluation of results with recommendations for further treatment as needed.

Post Treatment Findings and Indications for Specialist Referral

The continued presence of pocket depth with continued bleeding on probing may reflect the presence of residual deposits or ineffective plaque control. Additional professional care may be indicated.

• Persistent pockets of 3 to 4mm or more may require continued control of the inflammatory process with more frequent appointments for supportive periodontal treatment, perhaps alternating with a periodontist.

• Sites exhibiting pocket depth of 5mm or more are potential surgical candidates. However, the use of localized application of antibiotics may also be considered. These are good indications for consultation with a periodontist and perhaps a combined approach to care.

• Persistent evidence of disease activity, including bleeding on probing, may warrant bacterial culturing and DNA analysis. Such studies, coupled with an assessment of antibiotic sensitivity, may be more appropriately handled with referral to a specialist.

• Sites exhibiting pocket depths equal to or greater than 5mm in areas which will receive restorative procedures are candidates for referral for surgical or other appropriate pocket reduction treatments prior to restorative therapy.

• Sites with obvious bony and mucogingival defects and those requiring tissue augmentation are also candidates for referral.

• Patients requiring adjunctive procedures to enhance the results of restorative or cosmetic procedures would benefit from a consultation with a periodontist.

7. Continue regular monitoring and present the patient with alternatives in care. Guidelines should be developed for reviewing areas with evidence of persistent periodontal disease. This is often accomplished successfully during preventive maintenance appointments when comparison is made with previously recorded, good sequential documentation. This should include full mouth radiographs and/or vertical bite wings at appropriate intervals.

Areas exhibiting ongoing disease that are monitored and reported at regular recall intervals form the basis for behavioral and attitudinal changes. Patients recognize and relate to problems which remain in spite of our best treatment efforts. Presenting these findings in a manner which indicates every available preliminary alternative has been explored facilitates open discussion. This, in turn, removes the barriers to referral for more sophisticated periodontal treatment.

When analyzing the results of treatment, it is critical to understand that pocket depth is only one of the factors which determines periodontal health. Excellent documentation and a full discussion of all available treatment alternatives is the counterbalancing force to third party intervention, as well as the starting point to enhance patient confidence in the quality of care. Continuous improvement springs from ongoing education and training of doctor and staff.

A hallmark of the most successful restorative practices is their view of their periodontal colleagues as essential partners in the development of excellent treatment programs and achieving positive outcomes. We have found that doctors who partner with their periodontal colleagues in a team approach to treating their patients tend to enjoy a much higher level of acceptance of their proposed restorative treatment plans. It is axiomatic that patients tend to trust recommendations when they are endorsed by another respected professional who has nothing to gain directly as a result of those recommendations.

We appreciate the opportunity to participate in the treatment of your patients and to support your recommendations for comprehensive restorative treatment. We are delighted to provide resources to you and your staff in developing excellent "soft tissue management programs."

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