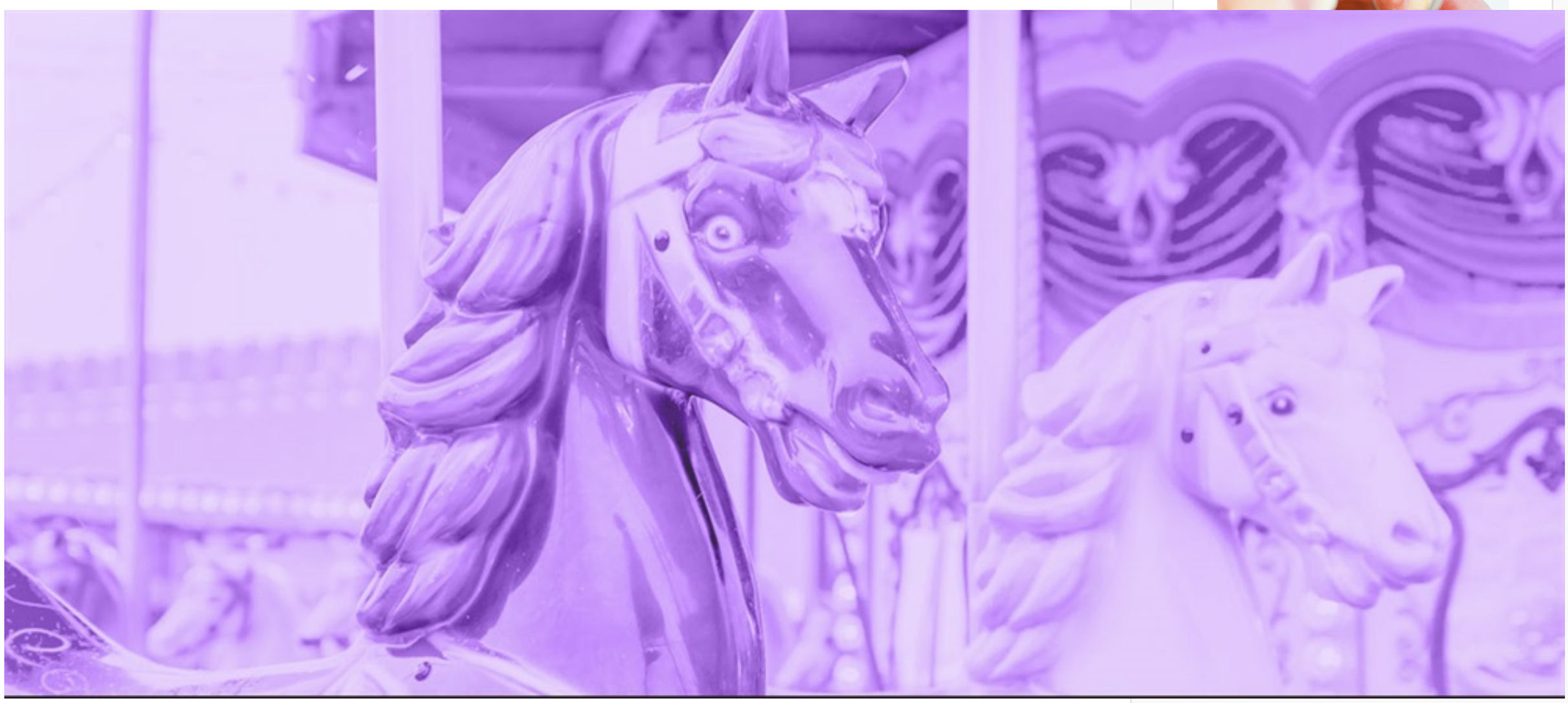
Getting Patients Off the 3-Month Merry-Go-Round by Nancy Adair



In an era of “periodontal medicine,” use evidence-based data to determine appropriate patient treatment

by Nancy Adair

Deep periodontal pockets that your instruments sink into; hemorrhaging that doesn’t seem to stop; sensitive raw-root surfaces; teeth that are so mobile you’re afraid you’ll remove them during the appointment … many hygienists experience these types of patients daily and can feel the stress, even if these patients aren’t in the chair!

As if those advanced periodontal patients weren’t enough to cause anxiety in hygienists, we also contend with dental implants with peri-implant diseases. Nogheria refers to this phenomenon as a ‘tidal wave’ of ailing and failing dental implants about to emerge in dentistry.[1] Ailing/failing implants are similar to natural teeth in disease process, whereby inflamed, tender tissues with bone loss exists around implants. Are we, as a profession, ready to manage these implant cases?

Perhaps it’s time we looked at these complex, unstable patients differently and got them *off* the every-three-months merry-go-round. How do we collect enough substantial scientific-based data, diagnose and intervene? What does intervention look like for natural teeth and dental implants, nonsurgically and surgically? This article will focus on the natural dentition [Fig. 1].

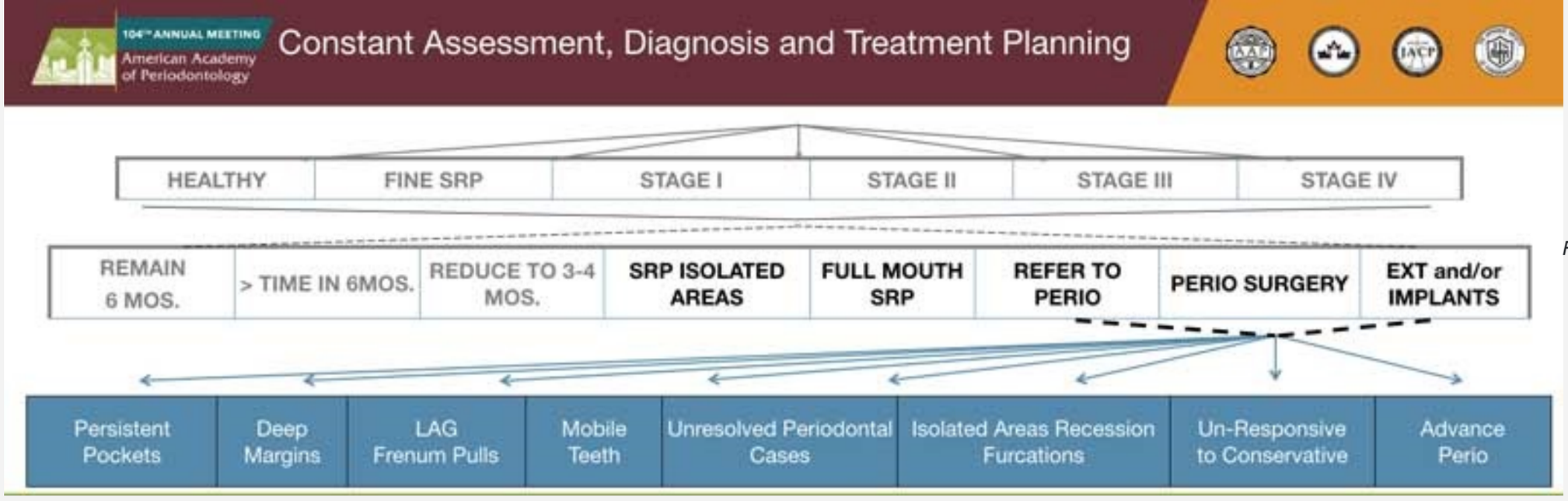
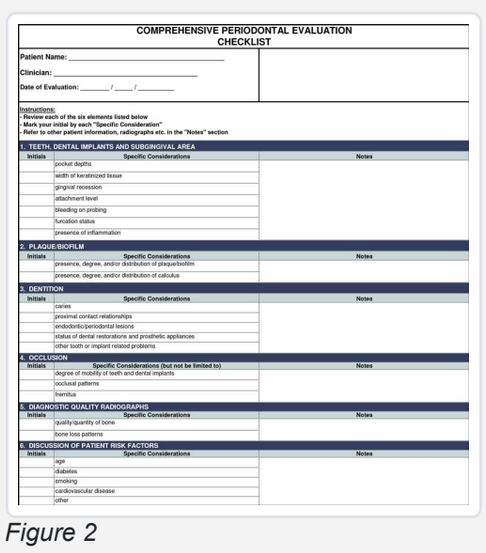


Figure 1

First, we need to rethink the hygiene practice and appreciate how dentistry has evolved. Dental professionals need to dismiss the decades-old mindset of "cleanings and checkups" and instead instill an office-wide culture that adopts comprehensive care, with hygiene services centered on being therapeutic and managing oral inflammation. The oral–systemic correlation has made dentistry a missing link to overall health because of the implications of oral inflammation to overall health. It is an incredible time to be working in dentistry when we are entering the era of "periodontal medicine."

The dental team and practice owner would benefit, by adopting the following protocols to integrate elements of a periodontal practice.

Execute a complete periodontal exam on all adult patients yearly



COMPREHENSIVE PERIODONTAL EVALUATION CHECKLIST

Patient Name: _____
Clinician: _____
Date of Evaluation: _____/____/_____

Instructions:
- Review each of the six elements listed below
- Mark your initial by each "Specific Consideration"
- Refer to other patient information, radiographs etc. in the "Notes" section

Initials	Specific Considerations	Notes
1. TEETH, DENTAL IMPLANTS AND SUBGINGIVAL AREA		
	pocket depths	
	width of keratinized tissue	
	gingival recession	
	attachment level	
	bleeding on probing	
	furcation status	
	presence of inflammation	
2. PLAQUE/BIOFILM		
	presence, degree, and/or distribution of plaque/biofilm	
	presence, degree, and/or distribution of calculus	
3. DENTITION		
	caries	
	proximal contact relationships	
	endodontic/periodontal lesions	
	status of dental restorations and prosthetic appliances	
	other tooth or implant related problems	
4. OCCLUSION		
	degree of mobility of teeth and dental implants	
	occlusal patterns	
	tremitus	
5. DIAGNOSTIC QUALITY RADIOGRAPHS		
	quality/quantity of bone	
	bone loss patterns	
6. DISCUSSION OF PATIENT RISK FACTORS		
	age	
	diabetes	
	smoking	
	cardiovascular disease	
	other	

Figure 2

The American Academy of Periodontology (AAP) outlines the procedure of a complete periodontal exam to ensure all areas are examined thoroughly, available here (Fig. 2). The AAP separates and collects data independently with natural teeth and dental implants. Natural teeth and implants are similar but yet different, so it's important to understand the differences.

Adopt the 2017 AAP guidelines for staging and grading periodontitis

The new AAP 2017 guidelines for staging and grading periodontitis can be viewed here. A summarized approach to the grading classification and the flow of new patients (NP) into patients of record (POR) can be seen in Fig. 3.

It's important to note that once NPs are treated, they become PORs—which can be a dangerous zone because this is where the merry-go-round begins. In many cases, patients stay too long on a 3-, 4- or 6-month interval and don't get assessed frequently enough to intervene with alternate treatment.

An important process often overlooked in dental offices is the periodontal re-evaluation exam. According to the AAP, adult PORs require yearly monitoring of their periodontal health. Many practices have restricted their hygiene services to 3-, 4- or 6-month intervals, when many PORs actually need surgical and nonsurgical interventions ("nonsurgical" meaning the patients go through a series of active scaling and root planning [SRP] with anesthetic). These appointments are often treated quadrant by quadrant or sextant by sextant, then re-evaluated. At the re-evaluation appointment, patients who haven't responded positively to nonsurgical treatment may require surgical intervention, either in-house or via referral to a periodontist.

It's critical to rely and compare the scientific-based data on adult patients that was collected over time. If adequate periodontal records do not exist, start acquiring data and then compare in a timely fashion. When starting to intervene with different options, move patients slowly through the continuum. For example:

- 6-month to 4-month intervals.
- 4-month to 3-month intervals.
- 3-month intervals to isolated areas with active SRP with anesthetic.
- 3-month intervals to full-mouth active SRP with anesthetic.
- 3-month intervals to isolated periodontal surgery.
- 3-month intervals to complete or limited periodontal referral.

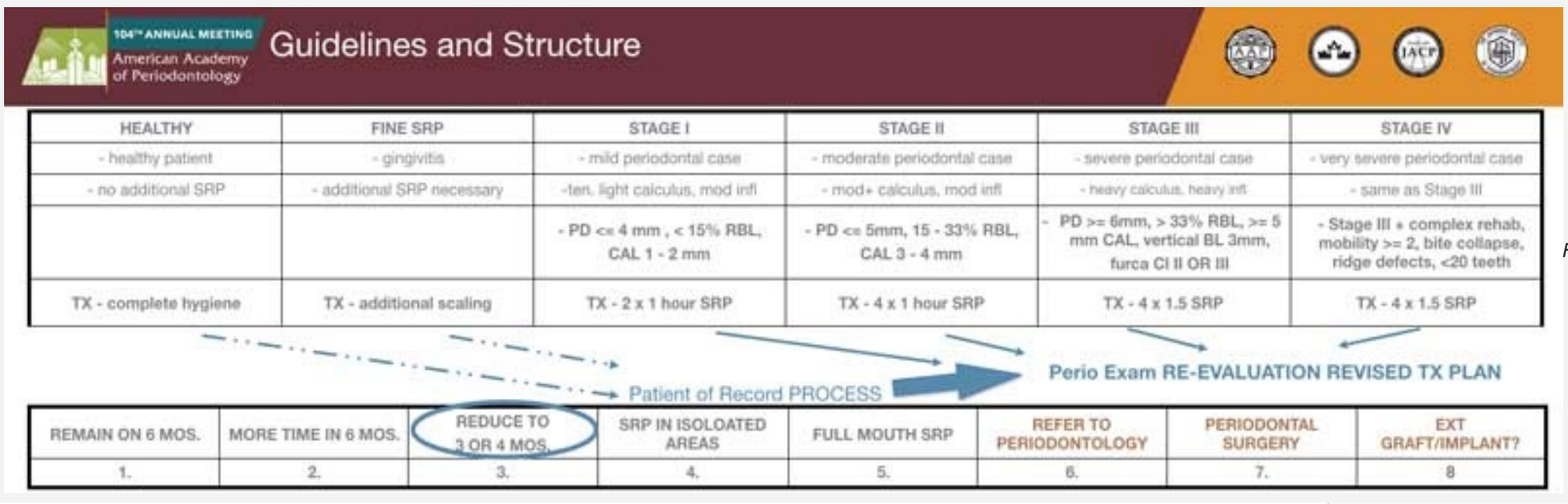


Figure 3

Update radiographs to include vertical bitewings and a full-mouth series, when clinical findings dictate

When doing recall exam radiographs, there are enormous benefits in taking vertical bitewings (VBWs), not horizontal bitewings. VBWs show more tooth structure, margins, decay, furcation involvement, quality of interproximal bone and bony defects, and approximate length of roots and periodontal ligament (PDL). According to Darby and Walsh, patients who have been affected by periodontal disease in the past should have a complete full-mouth series (FMS) at their new patient exam.[2] A FMS is typically 18 to 21 X-ray films; a common interval to update a FMS in a periodontal office is every 3 to 5 years.

Provide patients with nonsurgical and surgical periodontal estimates

Estimates that are required in dental practices are for nonsurgical and surgical periodontal interventions and treatments. It's important to make the estimates in a patient-friendly manner, because periodontal terms can be confusing and daunting. The estimates should discuss benefits and risks; codes; cost estimates with possible other incurred expenses; and a timeline with an expiry date to the estimate. Administrative staff and the patient should sign the estimate. Documents are scanned into the patient's file and a hard copy given to the patient.

Differentiate patient appointment types and instrument tray setups for the hygienists to address healthy patients and varying degrees of periodontitis

Many periodontal offices differentiate between the types of appointments—that is, maintenance versus active therapy. Two-hour sessions for active SRP patients are very advantageous because of the complexity of room setup, efficiency and reduction in sessions for the patient. Two different instrument kits often exist for hygienists, one being a "maintenance-style" kit (thinner blades, selection of scalers and curettes, and one or two ultrasonic inserts) and the other being an "active therapy" kit (thicker blades, ideally newer instruments, a wide range of scalers and curettes with accessory instruments and a variety of ultrasonic inserts, usually four or five).

Perform detailed chart reviews before the shift begins

Getting patients off the merry-go-round starts at the beginning of the day with a thorough chart review and referencing the patient's records with guidelines from the AAP, research papers and office-specific protocols. During the chart review, cases are flagged by the hygienist and then discussed scientifically and objectively in the morning meeting.

In many instances, offices are paying staff an additional 30 to 60 minutes for the chart review; this is an imperative process recognized by most offices. Areas to be reviewed in addition to medical history, previous procedures and treatments, previous dental and hygiene providers, and notes from previous appointments, include:

- Studying previous X-rays and comparing existing ones. Reading all areas on X-rays is important: decay, margins, quality of bone and bony defects, type and pattern of bone loss, stretched PDL, occlusal wear, furcation involvement, morphology of roots and anatomical significant findings.
- Reading previous clinical notes and referencing ledgers to ensure familiarity with previous procedures.
- Reviewing previous treatment and that which has been treatment-planned. This ensures no discrepancy in charting.
- Reading any referrals and letters from specialists.
- Reviewing current and past periodontal charts and findings.

A concern exists that too many teeth have been prematurely extracted when in fact we should be focusing on retaining teeth. Between nonsurgical and surgical therapy, many teeth can be saved for many years. Avila's article[3] helps to decipher some guidelines and create objective data for treatment plans. (See Table 1.)

Table 1

	Good Long-Term Success	Concerning Long-Term Success
Pocket Depth	< 5mm	5–7mm
Mobility	Class 0, Class I	Class II
Bone Loss	< 30%	30–65%
Furcation	Class I	Class II
Interproximal bone	Above furcation	At furcation
Presence of calculus	Yes	No
Root proximity	Root distance > 0.8mm	Root distance < 0.8mm

Additional periodontal risk factors and indicators, according to the *Journal of Periodontology*,[4] are:

- Early onset of periodontal disease (before age 35).
- Unresolved inflammation.
- PD equal to or greater than 5mm.
- Vertical bone defect.
- Radiographic evidence of progressive bone loss.
- Progressive tooth mobility.
- Progressive attachment loss.
- Anatomic gingival deformities.
- Exposed root surfaces.
- Deteriorating risk profile.

It's important to know before recommending a series of active SRP appointments whether the patient has received such therapy recently. Questions to ask are: when, by whom, where and whether outcomes were tracked. Know before you go!

If patients have had thorough active SRP and have been compliant every 3 months for at least one year, but still show signs of inflammation and instability, perhaps surgery is required. The following are common surgical procedures with natural dentitions:

- Pocket reduction with resective or regenerative procedures.
- Open flap debridement.
- Osseous recontouring.
- Crown lengthening.
- Gingival grafts.
- Bone grafts.
- Frenectomies.
- Hemisections.
- Periodontal splinting of teeth.

[*Editor's note: Criteria for surgical interventions will be included in Nancy Adair's next article.]*

Construct an intentionally effective start-of-the-shift meeting.

The start-of-the-shift meeting sets the stage for patients getting off the 3-month merry-go-round. By studying the past of each and every patient, suggestions are made and discussed at that meeting with the team.

It's imperative that the *entire team* be prepared for such patients getting off the merry-go-round, because patients may have questions about the change in their treatment plan. Doctors and hygienists can have a crucial conversation about getting off the merry-go-round behind closed doors before the day goes "live." It's best to keep discussions objective and base the treatment plan on acquired data in the patient's file. If adequate data does not exist, perhaps wait until enough data has been gathered to ensure the next step is evidence-based.

References

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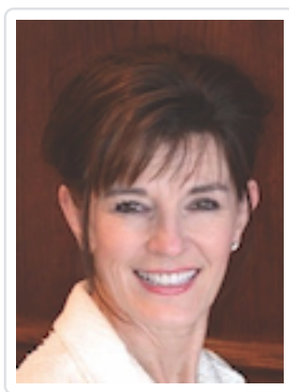
Author Bio



Nancy Adair's *journey in dentistry and dental hygiene have enabled her to be a source of knowledge on the evolution of dentistry. Adair is a motivational international speaker, a dental educator, a past CE chairperson, a transition leader, a clinical supervisor, a research team member on implants, a periodontal hygienist and the founder and owner of the CE company Hygiene Excellence.*