We have had lectures about sequence - but when Dr. Reidy says initial preparation = hygienic or disease control phase

- Diagnosis of periodontitis always includes periodontal re-evaluation in treatment plan
- Classically, maintenance is the final phase of treatment

Periodontal disease control always begins with patient education
- Plaque control, diet, smoking cessation, impact that systemic health has on control of disease
- Local factors - poorly contoured restorations, anything that contributes to plaque accumulation.
- Can’t change host resistance but can encourage discussion and education on controlling systemic disease (ex. Diabetes since it exacerbates periodontal disease. Ex. stress - inflammatory process control)
- Immunocompromised

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Periodontitis treatment plan will include re-evaluation

Gingival conditions - don’t make decision to move on in therapy just based on plaque score. Have to look clinically at signs of gingival inflammation and bleeding on probing.
- Hope that at end point of initial therapy that end point will have bleeding score reduced (11% or under) before saying you can move on in decision making
  As reduce inflammation from periodontal inflammatory process, that periodontal pocket - should see change in tooth mobility

Scaling and root planing and occlusal therapy here: Not finalized in initial phase since restorative casts, partials, bridges, might refine occlusal therapy.
- Occlusal therapy = Starts in the initial preparation phase!

Gingival recession - can try to cover roots back
Want gingival margin not mobile as a result of the recession.

Once controlled all diseases (caries and periodontitis) can move to restorative phase (“corrective phase” at UMBSOD)

Complete surgical phase, get periodontal health BEFORE removable or fixed restorations. Need sound foundation

Exam 2 Page 1
Complete surgical phase, get periodontal health BEFORE removable or fixed restorations. Need sound foundation

Initial preparation is simple restorations. And can be done prior to periodontal health in the initial phase. BUT NOT fixed and removable - that comes after gingival health

Always an assessment at every recall appointment
Then do all the supportive therapy the patient requires
Can't expect optimal healing without maintenance nor adequate long term results

Three prongs of maintenance = assessment, support, prevention

Main reason why we want to prevent disease recurrence by removing etiology and maintaining mouth with adequate home care.

Tissue destruction -> reverse architecture that is attempted to be corrected surgically, but need to reinforce home care after we do treatment so not recurring
Can’t do too much about host resistance
  - Need to be able to pick up on changes with patients - economic changes, periodontium and overall health, chronic illnesses, aging, flossing still
  - Why we need to see on regular intervals

Talk about maintenance as you begin the treatment plan
  - Once diagnose with periodontitis, tell patient one intervention of scaling and root planing is the beginning of a lifetime commitment to regular cleanings more than 2 x a year (4 x a year) to prevent recurrence. Prior to periodontal surgery
  - Looks like your fault if they need surgery and you never discussed how to prevent that

Don’t just say, “you need to do this” - explain significance
Need them to be successful so your dental work will survive as well as their dentition

Traditional sequence is not accurate in real life
Really need to consider maintaining patient as soon as finish re-evaluation appointment
Takes time to get definitive restorative treatment, or going into surgical phase. Full mouth of disease, not getting full mouth of periodontal surgery in a week. Might take months or years. Time, finances, other issues and demands orally. Going back and forth
Key - once finish initial prep, set schedule for maintenance intervals to prevent and maintain what you already accomplished with initial non-surgical intervention
  - Maintenance listed as “4th” or “last” stage of treatment planning but really is sandwiched in the middle

Recently completed two dental implants.
Lots of crown and bridge
Focus on how to maintain that right at the beginning (Ex. in image, proxabrush to clean newly restored implants)
Divided by original identification of prognosis from 600 patients

- WM lost 0.68 teeth in that time frame

- Other groups: D (downhill) lost 13.3 teeth on average

- Total was 1.8 teeth lost on average, but there were subsets that were losing more teeth

- Different reasons based on factors discussed above (why you assess at beginning of maintenance visit)

- Recognize there are differences between our patients and who is in each group then prevent losing those teeth!

- Other groups: D (downhill) was 5.7, ED (extreme downhill) lost 13.3 teeth on average

Differences in the well maintained (WM) group compared vs the other groups

- Table outlines classic periodontal longitudinal study of maintenance population in periodontal office over 22 years.

- Not all patients are the same

- Probing depths increased when didn’t have treatment

- Improved with treatment and no MT

- Sometimes when MT alone does not maintain tooth loss

- Then decreased with Tx and MT

- Amount of tooth loss followed the trend in probing depths of hard tissue lesions.

- Still double amount of tooth and bone loss with treatment and no maintenance.

- PRN = as needed

- Polishing is really for esthetics.

- Identify periodontal and restorative needs: biopsy, soft tissue lesions, etc.

- Always start at the beginning even if they have been in practice for a long time - review medical and dental history to isolate changes and if impact periodontium

- Plaque control - disclosing patient with staining of plaque

- Assessment of medical status and chief complaint and dental history = starts every appointment!

- Maintenance patient becomes the hub of making sure you identify treatment needs before they come in in crisis and emergency - better they don’t come in with abscess and you identify the issues before it gets to that stage

- Maintenance interval is specific to that patient

- Age - young patient with severe disease, like aggressive periodontitis, want to attend to more frequently because of nature of disease and that they have longer to be experiencing plaque related inflammation

- Risk assessment based on age even though disease isn’t necessarily

- Lots of bleeding on probing at each appointment could mean not great home care, need more frequent recalls until that gets under control.

- Host response - ex. not controlled diabetes. Need to see more frequently

- General rule of thumb outside of caries risk, just periodontal condition

- Periodontal patients always start with full mouth series and might only have vertical bitewings annually. Consider another full mouth series if progression of disease
Dr. Reidy’s Board certification case!

This patient completed periodontal surgery, now one year after - this is the presentation:
- Some root exposure at the red arrow
- Blunted papilla at blue arrow
- Band of erythema

- This was a motivated patient and still was having this result.
- Might need to give different style brushes to get area clean

Patient has to use proxabrushes as part of routine

Purple color shows statis, necrosis

Circle is a purplish area that needs more help in cleaning

Lateral had recession on the facial aspect

Treatment: new crowns, might be less than ideal
- Plaque retentive
Tissue tone around the crown

Not getting lingual aspect well - cyanotic appearing tissue

No further bone loss, but challenges in appearance of gingiva due to maligned teeth

Gingivitis in that area of malignment

Shorten recall interval

**Oral Examination**
- Factors indicated recent abnormality
  - Hemorrhage, ulcer, edema
  - Increased mobility
  - Increased or unusual bone loss
Retentive factors = need to intervene and show them how to clean the crown. If can remove and replace it, should do that.

Recently identified with systemic disease = shorten recall interval

Sudden rise in caries index = shorten recall interval

A lot of it is in the general dentist practice = mild patients.

Moderate = might be alternating general dentist and periodontist.

Advanced = want with specialist

Compliance is an issue; full compliance is rare. Most are erratic in compliance.

Numbers have improved now that this is recognized as a problem - higher rate of return than this 1984 study.

But as time goes on, less and less compliance. Need to emphasize that it is important to return for maintenance.

Patients in three different evaluations comparing outcome of attainment and maintenance of periodontal health - worsening occurred in cases that only stayed with general dentist.

Need to recognize downhill or extreme downhill based on host resistance.
Ones with mild disease are better compliers with maintenance intervals.

Maintenance needs to be at center of treatment plan from the beginning.

Always at risk once you have periodontitis. Not something that once you are in good shape, you are done.

These study questions are also in the lecture outline.
Treatment Plan

-些什么
-治疗方案
-治疗程序
-治疗效果
-治疗计划
-治疗内容
-治疗步骤
-治疗时间
-治疗地点
-治疗费用
-治疗护理
-治疗注意事项
-治疗后的复查
-治疗后的跟进