

Periodontics

General Guidelines

Periodontics consists of the diagnosis, treatment and prevention of pathologic, abnormal, or unesthetic conditions affecting the supporting tissues of the teeth, and their replacements (implants), including the gingiva, the periodontal ligament, and the alveolar bone. Each patient must be evaluated and diagnosed taking into account all local, systemic and environmental conditions which could affect the outcome of periodontal therapy.

The clinical examination of the periodontal patient should record the presence or absence of inflammatory and non-inflammatory abnormalities (usually manifested by the color and texture of the gingival tissues), the condition and stability of the dentition and the depth of periodontal pockets. Significant areas of recession, mobility, open or improper contacts, furcations, abnormal, occlusal contacts, interferences or presence of trauma, bleeding or exudates, and degree of tooth born deposits should also be recorded. Mucogingival problems such as shallow vestibule, abnormal frenum pull or lack of attached gingival should be noted. Radiographs, CT's, tomographs may also be used as additional diagnostic tools to evaluate the condition and anatomy of alveolar bone and teeth. Restorative, periodontal and endodontic needs as well as pathologic or relevant anatomic conditions must be diagnosed both clinically and radiographically and appropriately incorporated into a treatment plan.

Children, adolescents, and adults should be screened for evidence of periodontal disease. Where evidence of disease exists, patients should be examined, probed and charted to provide baseline information of the periodontal condition and informed of the presence of any periodontal disease. A notation regarding the results of a periodontal examination should be made in the patient's record, whether or not the dentist treats the condition, refers the patient, or the patient does not elect treatment at that time. The periodontium should be evaluated for signs of disease as part of orthodontic treatment planning. Orthodontic therapy should be preceded by appropriate periodontal therapy, because orthodontic tooth movement in the presence of inflammation can contribute to irreversible bone loss.

For purposes of assessment, this manual considers root planning and scaling, periodontal surgery and case results and management. Scaling and root planning should result in removal of biofilm, smoothing root irregularities and roughness, removal of accessible sub-gingival deposits and leave a root that feels smooth and hard. It should be realized that deposits beyond 4 mm and those anatomically inaccessible will most likely be left behind. Adjunctive use of slow released topical antimicrobials could be performed on selective sites however clinically significant improvement over scaling alone may prove to be minimal. In most instances, after scaling a period of healing (usually 4-6 weeks) a re-evaluation of the periodontal condition should be made and the need for further active therapy assessed. However, there are times when initial preparation can be bypassed (acute infection, need for visual access to the subgingival area to remove or expose irritants or abnormalities, need for crown lengthening, etc.) and an immediate surgical approach without pre-scaling would be in the patients best interest. There are also times when an exclusively non-surgical approach with careful monitoring can be instituted. These options should be left up to the clinical judgement of the individual practitioner with the informed consent of the patient.

The purpose of periodontal mucogingival flap surgery is primarily access, secondarily pocket reduction, and finally ability to perform regenerative procedures. Periodontal flap surgery may be accomplished by a variety of scalpels or other cutting devices. Gingivectomy, flap, osseous

and other mucogingival periodontal surgery should result in the reduction or elimination of periodontal pocketing. The gingiva should be restored to appropriate physiologic form commensurate with health albeit sometimes at a more apical position. Deformities in the alveolar bone are corrected by osteoplasty and/or osteoectomy or regenerative procedures such as bone grafting or guided tissue regeneration or use of growth factors or other biologicals. Flap access is required for alveolar bone related procedures.

Gingival curettage is the intentional removal of the soft tissue compromising the sulcular wall via blade, laser, etc. It is not supported by scientific evidence as a definitive procedure or as a supplement to scaling and root planning.

The amount of attached gingiva considered to be adequate will vary with clinical conditions. Gingival augmentation procedures should ideally be performed when there is inadequate attached gingival tissue. The adequacy of attached tissue will vary depending on local factors (ie: subgingival restoration, ortho, etc.). There are a variety of surgical methods available to accomplish these ends such as pedicle, free and oblique grafts as well as guided tissue regeneration. Periodontal plastic surgical procedures can be performed for esthetics or sensitivity and in cases where continued increased recession has been documented. Procedures such as pedicle, connective tissue, guided tissue regeneration and dermal grafts have been used to augment both teeth and edentulous ridges. Gingival reduction procedures are also available to reduce gingival display or gingival overgrowth.

Directly following treatment, clinical examination ideally should evidence healthy tissues, absence of inflammation and gingival bleeding, acceptable gingival form and reduced levels of bacterial plaque and calculus and a non-traumatic occlusion. It is critical that from the onset the patient should be trained and evaluated in skills for plaque control procedures, preferably using an objective means such as a plaque index. A follow-up program for evaluation of the success of treatment, continuous supportive therapy and maintenance program should be established. The maintenance interval for a patient with a history of periodontitis is usually every 90 days but can vary depending on each patients needs. The condition of the periodontal tissues, the significant pocket depths and the future plan of treatment should be recorded at each maintenance visit.

The following quality-evaluation criteria should be considered merely as AIDS for the discrimination between the four ratings for each characteristic. The determination of the rating of any given dental service is dependent upon the sound JUDGMENT of the peer review examiners.

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PERIODONTICS

QUALITY EVALUATION RATING SYSTEM					
		Rating	Operational Evaluation	Code	Root Planing and Scaling*
S A T I S F A C T O R Y	R	Range of Excellence	The periodontal treatment is of satisfactory quality and is expected to contribute to prevention of caries and/or periodontal disease.		Irregularities and roughness and deposits have been removed and the roots smoothed. (Refer to General Guidelines.)
	ROMEIO	Code: R Call: Romeo			
S A T I S F A C T O R Y	S	Range of Acceptability	The periodontal treatment is of acceptable quality, but exhibits one or more features which deviate from the ideal.	SSM	A smooth, optimally cleansable root surface has been achieved in most areas, but there are still teeth or parts of some roots that should have more smoothing at a future time.
	SIERRA	Code: S Call: Sierra			
N O T S A T I S F A C T O R Y	T	Repeat or Correct for Prevention	The periodontal treatment is not of acceptable quality. Future damage to the teeth and/or their surrounding tissue is likely to occur.	TSM	Inadequate removal of deposits and/or no smoothing on the roots has been done.
	TANGO	Code: T Call: Tango			
N O T S A T I S F A C T O R Y	V	Repeat Statim	The periodontal treatment is not of acceptable quality. Damage to the teeth and/or their surrounding tissue is now occurring.	VDM	Root planing and scaling has resulted in permanent damage to tooth structure.
	VICTOR	Code: V Call: Victor			

* Scaling is defined as the procedure designed to remove calculus and bacterial plaque from the teeth (also see under PROPHYLAXIS). The term subgingival curettage is used interchangeably by some practitioners to mean scaling and root planing, but is not to be confused with tissue surgical curettage listed under periodontal surgery.

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QUALITY EVALUATION CRITERIA AND ABBREVIATIONS					
Code	Gingival Grafting	Code	Gingivectomy, Flap, Osseous, Muco-gingival and All Other Periodontal Surgery	Code	Case Results and Management
	No clinical sign of inflammation is evidenced by bleeding or purulence upon probing. There is adequate attached gingival. Root coverage has been accomplished where attempted. (Refer to General Guidelines.)		Gingiva is restored to appropriate physiologic form and deformities in the alveolar bone have been corrected. Pockets have been reduced. There is evidence of bone regeneration where attempted. (Refer to General Guidelines.)		Clinical examination records satisfactory treatment. A stable periodontium. A recall schedule has been established and is being followed. (Refer to General Guidelines.)
SSI	There are some isolated areas of inflammation . The amount of post grafting attached gingival is minimal but acceptable. Some root coverage has been achieved, where attempted.	SCP	There are some areas of periodontal compromise but the patient can maintain the mouth in an acceptable state of health. Most pockets have been reduced. Evidence of some bone regeneration is demonstrated or has not been accomplished because of patient non-compliance.	SCP SPF	Clinical examination reveals a health mouth, but there are some areas of compromise due to anatomical and aesthetic considerations or limited patient cooperation. A recall schedule was established, but the patient failed to return or has not carried out oral hygiene as instructed and demonstrated.
TNGA	No attachment gingival remains. Minimal or no root coverage has been achieved, where attempted. The patient has not been informed of his/her condition and no plan for improving or following up the condition has been made.	TPAT	Surgery has not eliminated or controlled the problem it was performed to correct. Bone regeneration has not been accomplished because of operator error. Appropriate maintenance or follow up has not been established or recommended by the dentist.	TCM	The treatment plan was not completed or followed by the dentist. An adequate post treatment maintenance interval has been established by the dentist. The patient never demonstrated the ability to carry out adequate plaque control prior to surgical therapy.
VLTO VMRR VPNI	There is less attached tissue than original. There is more root exposure than original. The patient has not been informed of his/her condition and no plan for improving or following up the condition has been made.	VPAT	Surgery has aggravated the periodontal condition and the condition is worse than original. The patient has never been informed of or demonstrated the ability to comply with necessary oral hygiene and maintenance requirements.	VCD	Clinical examination reveals continual deterioration without remedial intervention. The practitioner failed to diagnose the condition, realistically prognosticate or formulate an appropriate treatment plan or carry it out.

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