TEAMWORK FOR TREATING PERIODONTAL DISEASE

The treatment of patients with periodontal disease should involve the application of standard procedures based on commonly accepted guidelines. This “Periodontal Treatment Guide” aims to support local networks of general dentists, hygienists and periodontists by providing evidence-based guidelines for diagnosis, referral and treatment options.

The “Periodontal Treatment Guide” is the result of a consensus established by a group of experienced and highly renowned periodontists who based their recommendations for these guidelines on the systematic assessment of the available literature. The final goal of these activities is to help you to improve periodontal therapies in order to restore oral health and help preserve the teeth of the patient.
PERIODONTAL TREATMENT

WE ARE THANKFUL TO THE FOLLOWING AUTHORS FOR THEIR SIGNIFICANT SUPPORT IN DEVELOPING THIS “PERIODONTAL TREATMENT GUIDE”

Prof. Dr. med. dent. Anton Sclaean, Dr. h.c., M.S., Chairman of Department of Periodontology – School of Dental Medicine – University of Bern – Bern, Switzerland. Dr. Christina Tietmann, Certified periodontal specialist of the German Society of Periodontology – Private Practice for Periodontology – Aachen, Germany. Dr. David Nisand, Lecturer of periodontics at the University of Paris – Private Practice limited to periodontology and implantology – Paris, France. Dr. Frank Bröseler, Certified periodontal specialist of the German Society of Periodontology – Private Practice for Periodontology – Aachen, Germany. Dr. Holger Janssen, Specialist for periodontology, implantology and restorative dentistry – Private Practice – Berlin, Germany. Dr. Mario Roccuzzo, Lecturer in Periodontics at University of Torino and Siena. Private Practice limited to Periodontics and Implantology – Torino, Italy. Dr. Markus Schlee, Lecturer for periodontics and implantology at the Steinbeis University, Berlin and DIU, Dresden, Germany. Private practice limited to periodontology and implantology – Forchheim, Germany. Prof. Dr. Nick Donos, DDS, MS, FHEA, FDSRCSEngl, PhD., Head & Chair of Periodontology, Director of Research, UCL-Eastman Dental Institute – Department of Periodontology – London, United Kingdom.
PERIODONTALLY HEALTHY PATIENT

ORAL CHECK

MAINTENANCE PHASE

TO CHECK
Oral hygiene, tobacco consumption, periodontal status, furcation involvement, X-ray status, general health

TO DO
Oral hygiene motivation
Instruction
Disinfection

EVALUATION
PPD ≤ 4 mm
FMP5 ≤ 20%
BOP ≤ 20%
SUCCESSFUL

NOT SUCCESSFUL

PROPHYLAXIS
Preventive long-term care
PATIENT WITH PERIODONTAL DISEASE

SYSTEMIC PHASE AND PERIODONTAL DIAGNOSIS

EVALUATION

- Moderate chronic periodontitis
  - PPD ≤ 6 mm
  - Without intrabony defect

- Severe chronic periodontitis or aggressive periodontitis
  - PPD > 6 mm with intrabony defect
  - With furcation involvement (class II or class III)

- Necrotizing periodontitis

- Periodontitis with systemic disease
- Special case of periodontitis
  - PPD > 6 mm Profuse bleeding or pus

TO CHECK

Oral hygiene, tobacco consumption, periodontal status, furcation involvement, X-ray status, general health (systemic diseases, e.g. diabetes, circulatory problems, etc), stress, pregnancy

Consider also the removal of inadequate restorations, optional splinting before surgery, use of microbiologic tests, involvement of general physician and extraction of hopeless teeth.

Regarding hopeless teeth the following factors should be considered: bone loss, clinical attachment loss, degree of mobility, endodontic factors, restorative factors, anatomy and tooth position.

TO DO

Refer to a specialist

PROPHYLAXIS

Preventive long-term care

Optionally not via specialist
PATIENT WITH PERIODONTAL DISEASE

TO DO
- Motivation for oral hygiene instruction
- Plaque control

TO DO
- Non-surgical periodontal treatment i.e. supragingival and subgingival SRP

RE-EVALUATION
- 2nd CHANCE
- PPD ≤ 4 mm
- FMPS ≤ 20%
- BOP ≤ 20%
- SUCCESSFUL

RE-EVALUATION (3 MONTHS)
- NOT SUCCESSFUL
- PPD ≤ 4 mm
- FMPS ≤ 20%
- BOP ≤ 20%

PROPHELYAXIS
- Preventive long-term care

PERIODONTAL SURGERY OF MULTI-ROOTED TEETH WITH FURCATION INVOLVEMENT (CLASS II AND III)
SURGERY – WITH FURCATION INVOLVEMENT (CLASS II AND III)

**MAXILLA**

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**RE-EVALUATION**

**SUCCESSFUL**

**PREVIA**

Preventive long-term care

**TO DO**

First postoperative care

**GO TO NEXT PAGE**

**SURGERY – WITHOUT FURCATION INVOLVEMENT (PPD > 6 MM)**

**HORIZONTAL BONE LOSS**

Conventional periodontal flap surgery

Conservative or resective approach according to site characteristics

**ANGULAR BONY DEFECT**

Site mapping for defect localization, e.g. bone sounding

Regenerative surgical technique designed to maintain the interdental soft tissue

**SUCCESSFUL**

**PREVIA**

Preventive long-term care

**TO DO**

Reconsider diagnosis and treatment plan. Further non-surgical therapy, if necessary.
POST-OCCUPATIVE CARE (AFTER PERIODONTAL SURGERY)

Use of antiplaque oral rinses (e.g. 0.1–0.2% chlorhexidine solution) for 3–6 weeks

Optional use of systemic antibiotics

Removal of sutures when they are no longer necessary for wound stability (usually after 10–14 days)

No brushing in the operated area for at least 2–3 weeks, professional postoperative care once a week

No sulcus or interproximal tooth cleaning for at least 3–4 weeks post-op/until stable or interproximal

After 3 weeks gentle brushing of the buccal and lingual tooth surfaces with a “wiping technique”

No sulcus or interproximal tooth cleaning for at least 3–4 weeks post-op/until stable or interproximal conditions are achieved

Regular check-up by dentist – individual recall program

THE FOLLOWING PUBLICATIONS HAVE BEEN CONSULTED BY THE AUTHORS:

Lund, Lindhe, Clinical Periodontology and Implant Dentistry (5th ed.). 2008;623-627


Lang N, Schenck, A, motivation and education. SSO Schweiz monatsschr Zahnheilkd 1975, 85, 905-919


Weitzel H, How HR, Evaluation of Human bone defect filled treated with coronally advanced flaps and either enamel matrix derivative or Connective tissue. J Periodontol 2003, 74, 1100-1103

Weitzel H, Calvi, ML, Evaluation of Human recession defect filled treated with coronally advanced flaps and either Enamel Matrix Derivative or Connective tissue. J Periodontol 2003, 74, 1100-1103

Carone MA, Balbi FE, How HR, Bone Healing 1, Bone: A comparative study of coronally advanced flaps with and without the addition of enamel matrix derivative in the treatment of intrabony lesion. J Periodontol 2001, 72, 1557-1562


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