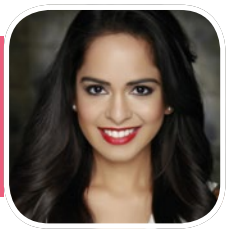
A brief perio update



Millions of people in the UK have perio; here, specialist periodontist **Reena Wadia**, taking into account the revised system of classification, advises on managing both patients and their disease.

There is now overwhelming evidence that periodontal disease has a negative impact on patients' quality of life,[1] and it also tops the list in terms of litigation. It is important to identify potential risk factors when taking each patient's medical and social history, as this can provide immediate warning signs of what type of care they may require. Everything from smoking habits and stress levels to diabetes should be recorded. This last one is particularly important right now, as in the UK, there are almost 3.7 million people who have been diagnosed with diabetes.[2] By 2025, this number is estimated to have risen to 5 million.[3] Perhaps more importantly, there are approximately 1 million undiagnosed cases of diabetes in the UK and 17 million across Europe. These people may regularly attend dental practices, providing an opportunity for the oral healthcare team to engage in prevention strategies and early detection.[4]

As is true in any field of dentistry, the first step is always about patient communication and education. They need to understand the risk factors for periodontal disease and appreciate their role in minimising the opportunity for disease progression. Unfortunately, we don't usually have more than 5-10 minutes in general practice to provide oral hygiene instructions, but there are some techniques you can use to deliver effective education within the available timeframe. An important one is the use of 'GPS'. This is an evidenced-based approach to change oral hygiene behaviour that is based on: Goal setting (including instruction in an appropriate technique to achieve that goal), Planning (a target plaque score by a certain time) and Self-monitoring (for example, through the use of disclosing tablets at home).[5]

For those patients with established periodontal disease, effective management is key to preventing an array of serious consequences. Wherever possible, non-surgical periodontal therapy is the first choice of treatment. We no longer vigorously remove cementum/root structure as endotoxins have been shown to be superficially attached.[6,7] There is also no evidence that one technique or regime is superior to another.[8] Generally, when it comes to deciding between quadrant, half mouth or full mouth debridement, this is dependent on: severity of disease, need for anaesthesia, patient anxiety, level of plaque control and logistics. The evidence from a recent review on the use of lasers in the treatment of periodontitis remains conflicted and insufficient to suggest its use in everyday periodontal management.[9] In addition, despite some confusion among the profession as to when and how periodontal treatment can be provided and claimed for under the NHS, it is possible and there are resources available to help simplify the process for clinicians.

Correct diagnosis and effective management of periodontal disease is crucial, not only for the dental and general wellbeing of patients, but also for the legal protection of the clinician. Periodontitis is at the top of the list in terms of litigation, with failure to diagnose and treat the condition the most common reasons for complaints.[10] There are more periodontal claims than there are for seemingly more complex surgical fields of dentistry like maxillofacial surgery. Minimising the risk of litigation is therefore essential for clinicians and this all starts with thorough and accurate record

Reena Wadia, Specialist Periodontist

Reena qualified from Barts and The London with the prestigious Gold Medal as well as numerous other undergraduate dental awards. Following general practice, Reena worked as a Senior House Officer in both Restorative Dentistry and Oral Surgery. Reena has completed the part-time speciality training programme in Periodontology at Guy's Hospital. She now runs her own specialist periodontal referral clinic at Lister House on Wimpole Street and is also an associate specialist at King's College London.

keeping. It is also necessary to understand when a patient requires referral to a specialist in order to gain access to the advanced treatment they may need. Reviewing the BSP (British Society of Periodontology) referral guidelines regularly is therefore advisable.

The new classification for periodontal diseases recently released should also be checked by clinicians. It was the result of a consensus between the European Federation of Periodontology and the American Academy of Periodontology. The 2017 World Workshop Classification system for periodontal and peri-implant diseases and conditions[11] was developed in order to accommodate advances in knowledge derived from both biological and clinical research, which have emerged since the 1999 International Classification of Periodontal Diseases. The new classification system defines clinical health for the first time and distinguishes between an intact and reduced periodontium. The term 'aggressive periodontitis' has been removed, with a staging and grading system provided in its place. The distinction between chronic and aggressive periodontitis has been removed on the basis that there was little evidence from biological studies that chronic and aggressive periodontitis were separate entities, rather than variations along a spectrum of the same disease process. The exception was classical localised juvenile (aggressive) periodontitis, where a clearly defined clinical phenotype exists, however, there was unease about including this as a distinct and separate entity within the classification system. Aligning with the medical approach to disease classification, the new classification encourages all practitioners to work with the same criteria. The BSP convened an implementation group to develop guidance on how the new classification system should be applied to clinical practice in the UK. This guidance is essential for all UK dental professionals.

By combining this new classification system with improved risk assessments, diagnostics, patient communication, disease management, record keeping and referral protocols, clinicians can enhance their periodontal patients' experiences while minimising the risk of any future litigation.

'THE DISTINCTION BETWEEN CHRONIC AND AGGRESSIVE PERIODONTITIS HAS BEEN REMOVED ON THE BASIS THAT THERE WAS LITTLE EVIDENCE FROM BIOLOGICAL STUDIES THAT CHRONIC AND AGGRESSIVE PERIODONTITIS WERE SEPARATE ENTITIES.'

References

1. Ferreira M C, Dias-Pereira A C, Branco-de-Almeida L S, Martins C C, Paiva S M. Impact of periodontal disease on quality of life: a systematic review. *J Periodontal Res* 2017; **52:** 651–665.
2. Diabetes UK. Professionals, Position statements & reports. Facts & figures. Diabetes prevalence 2017. 2017. Available at https://www.diabetes.org.uk/professionals/position-statements-reports/statistics/diabetes-prevalence-2017 (accessed January 2019).
3. Diabetes UK. Professionals. Position statements & reports. Facts & figures. Available at https://www.diabetes.org.uk/professionals/position-statements-reports/statistics (accessed January 2019).
4. Chapple I L C. Bleeding gums: Sentinels of non-communicable diseases of ageing. *Open Access Government*, 2018.
5. Tonetti M S, Eickholz P, Loos B G *et al.* Principles in prevention of periodontal diseases- Consensus report of group 1 of the 11th European Workshop on Periodontology on effective prevention of periodontal and peri-implant diseases. *J Clin Periodontol* 2015; **42 (Suppl 16):** S5–S11.
6. Hughes F J, Auger D W, Smales F C. Investigation of the distribution of cementum-associated lipopolysaccharides in periodontal disease by scanning electron microscope immunohistochemistry. *J Periodontal Res* 1988; **23:** 100–106.
7. Nyman S, Westfelt E, Sarhead G, Karring T. Role of 'diseased' cementum in healing following treatment of periodontal disease. A clinical study. *J Clin Periodontol*.1988; **15:** 464–468.
8. Sagar A. Full mouth versus quadrant treatment in chronic periodontitis. *Prim Dent J* 2014; **3:** 66–69.
9. Cobb C M. Lasers and the treatment of periodontitis: the essence and the noise. *Periodontol 2000* 2017; **75:** 205–295.
10. DDU. Probing deeper into periodontics claims. 2014. Available at https://www.theddu.com/guidance-and-advice/journals/march-2014/probing-deeper-into-periodontics-claims (accessed January 2019).
11. Caton J G, Armitage G, Berglundh T *et al.* A new classification scheme for periodontal and peri-implant diseases and conditions – Introduction and key changes from the 1999 classification. *J Periodont* 2018; **89(S1):** S1–S8.

Key points

- Almost 3.7 million people in the UK have been diagnosed with diabetes
- Patients need to understand the risk factors for periodontal disease and appreciate their own role in minimising disease progression
- Non-surgical periodontal therapy is the first choice of treatment for those with established disease
- Periodontal treatment can be provided and claimed for under the NHS
- The new classification for periodontal diseases recently released should be familiar to clinicians
- It defines clinical health for the first time and distinguishes between an intact and reduced periodontium.

Dr Reena Wadia will be one of several speakers in the BDA Theatre at the British Dental Conference and Dentistry Show May 17-18 2019. Her talk will provide a whistle-stop tour of all the essential periodontal topics relevant to general practice. For more information, visit: www.thedentistryshow.co.uk *or for more information about Reena, go to:* www.reenawadia.com.

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