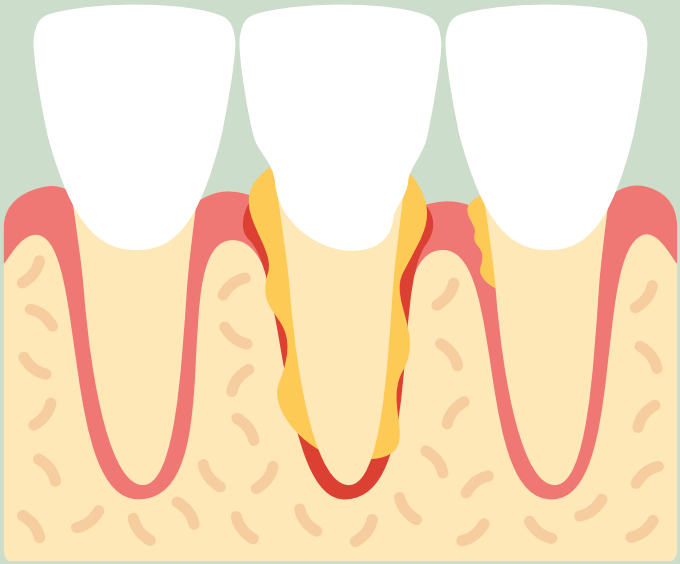
Clinical health at the **heart** of new perio classification

Dental hygienists and therapists have all responded positively to the new perio classification system – **Caroline Holland** shares the insights of organisations and individuals.



The perio specialty enjoys unparalleled international collaboration. The recently released classification system is a perfect example. The result of a world workshop in 2017 organised by the European Federation of Periodontology (EFP) and the American Academy of Periodontology (AAP), it represents a major step forward.

Key aspects are that it defines clinical health for the first time and distinguishes between an intact and a reduced periodontium throughout. Moving forwards, periodontitis is classified into four stages based on severity and three levels based on susceptibility.

While a little daunted by the new system, dental hygienists and therapists have all responded positively and have expressed their appreciation of the work of Thomas Dietrich and team at Birmingham University Dental Hospital and the British Society of Peridontology who together have created implementation guidance for general practice.[1] A flowchart to support the new system is now available on the British Society of Periodontology (BSP) website.[2]

References

1. T. Dietrich, P. Ower, M. Tank, *et al.* Periodontal diagnosis in the context of the 2017 classification system of periodontal diseases and conditions – implementation in clinical practice. *Br Dent J.* 2019 **225:** 16-22.
2. British Society of Periodontology. Publications 2019. Online information available at: http://www.bsperio.org.uk/publications/downloads/111_153050_bsp-flowchart-implementing-the-2017-classification.pdf (accessed February 2019).

Mel Prebble

Dental hygienist at Abbey Road Dental and Neel Dentistry

In my opinion it's a progressive step as it joins the dots and allows us to consider all factors, health, disease, risk and so on. I am delighted we now recognise healthy periodontium and peri-implant diseases. The challenge is implementation, which will take us time, although I think this gives us an opportunity to review and refine and clearly define stages and grades of disease, and also potentially give our patients a better understanding of their disease or health status and subsequent care pathway.

With colleagues I have been reviewing the document, listening to the webinars and discussing the implementation strategy. This system is allowing us to review and consider our protocols.

Debbie McGovern

President of BADT

BADT welcomes the new periodontal classification and once clinicians are familiar with its use, it will represent a straightforward means of providing a named diagnosis for the periodontal disease the patient is presenting with. It will not change the way the disease is treated which is ultimately the most important thing.

As with all new systems, it will take some time to get used to, and BSP are to be congratulated on their down to earth approach in making the new system more user friendly and their generosity in sharing it with the whole profession. Their flow chart (http://www.bsperio.org.uk/publications/downloads/111_153050_bsp-flowchart-implementing-the-2017-classification.pdf) is a brilliant resource, and one which we will all rely on to help us while we get to grips with the new system. Thank you BSP!

Nichola Tong
A dental hygienist and lecturer

On first inspection, the new system may seem a little daunting with all the algorithms, charts, graphs and accompanying tables, but I found these elements to be what actually helped me make sense of it. As a hygienist with over 25 years' experience I have found that notating my periodontal diagnosis had been rather vague and subjective due to what now seems like a lack of detailed diagnostic written parameters. The new classification system of 2017 gets rid of a lot of the 'grey' and brings a new level of detail to help us arrive at:

- the appropriate gingivitis/periodontitis diagnosis
- the extent of involvement of each disease throughout the mouth
- the rate of progression.

It's a standardised stepwise tool that helped me write more specific contemporaneous clinical notes.

Dietrich *et al* (2019) acknowledge that clinical attachment loss (CAL) is not routinely measured in a clinical setting. This means that a lot of periodontal diagnoses may be falsely based on a BPE of 3, and conversely a BPE of 2, if used in isolation, may not give an accurate diagnosis of successfully treated historical periodontal disease.

By introducing a staging and grading system we can capture the extent of historical disease and help assess potential future tissue loss. Detailed guidance on interpreting percentage bone loss with available radiographs and/or actual CAL encourages us to record whether pockets are the result of a loss of tissue moving apically or upward tissue swelling (pseudo pocketing). By building on the traditional use of BOP and probing pocket depths we can recognise and manage a successfully treated stable periodontal patient, a patient in periodontal remission or someone with an unstable disease status.

In practice, I found it helpful to have a printed copy of the algorithms and charts to hand for reference. I also updated my clinical notes template to incorporate the distinction between diseases, historical percentage bone loss and/or CAL (staging), the extent and distribution of tissue loss and grading based on age. This also served as a prompt to remember to notate it!

We're not all going to get it right straight away, but by making an effort to show that we are trying, in the best interests of our patients, we should be protected medico-legally.

It will take time for the periodontal diagnosis culture to change but we should start familiarising and implementing. This will mean that our patients are screened more thoroughly, that mis-diagnosis or lack of diagnosis may be avoided and, therefore, litigation in this field may be reduced.

Julie Deverick
President of The British Society of Dental Hygiene and Therapy

We welcome the adapted guidelines from the British Society of Periodontology and their work to bring it to a wider audience with explanation and illustrated diagnostic pathways to aid in its implementation.

Diagnosis in a practice setting will still rely on the clinician screening the patient using the BPE, signposting the need to check radiographs for bone loss, measuring clinical attachment loss, bleeding on probing and pocket depths. The difference now will be the addition of the staging and grading of the patient with the third element being the patient risk factor profile.

How well this will be received in a clinical setting is yet to be seen. Some clinicians are already utilising it effectively but it will take time for a dentist, dental hygienist or dental therapist to feel proficient in its use; some have laminated the sheets as a quick guide to follow.

As with all treatments, if this is to be effective, time is required to follow the steps and this may not always be possible in some practices; once the patient has been identified as BPE 3 or 4, to be fair to the patient and the clinician, extra time is needed in order to effectively follow the classification system guidelines so that the treatment need can be established.

This system can work well in private and specialist practices but the current NHS contract is restrictive, especially for the dental hygienist and dental therapist, as their appointment times are constrained and the patient is required to be examined by the dentist for a new course of treatment. It also relies on all the clinicians in the practice following the guidelines, which presents further challenges.

These guidelines now allow the patient who has been diagnosed with periodontitis to be given very clear definitions for their condition and it can be explained that once they have that diagnosis, they will always be a periodontal patient – stable or unstable. A sentence that stands out is… *It is important to note that a higher probing depth of 5 mm or 6 mm in the absence of bleeding may not necessarily represent active disease, in particular soon after periodontal treatment…..* This gives the clear message that there may be no need to treat a pocket of this depth if it is not bleeding which is significant as many clinicians will do so at the moment. This is definitely a progressive step.

'THESE GUIDELINES NOW ALLOW THE PATIENT WHO HAS BEEN DIAGNOSED WITH PERIODONTITIS TO BE GIVEN VERY CLEAR DEFINITIONS FOR THEIR CONDITION'

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