The new classification of periodontal diseases

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explains
the newly

redesigned periodontal disease classification framework for the benefit of the whole dental team.

In 2017 the American Academy of Periodontology (AAP) and European Federation of Periodontology (EFP) co-presented the new classification for periodontal and peri-implant diseases and conditions at the world workshop.¹ This was to replace the Armitage 1999 classification of periodontal diseases, which had been used for nearly two decades.² This new redesigned periodontal disease classification framework included a multi-dimensional staging and grading system, the inaugural classification for peri-implant diseases and conditions and a recategorisation of various forms of periodontitis.¹ Many of those who were first introduced to the new system felt it was only suitable for use by researchers and specialists, thereby excluding dental therapists, dental hygienists and general dental practitioners, who treat a significant number of the periodontal disease cases.

The new worldwide classification was based on interproximal clinical attachment loss.¹ This is due to clinical attachment loss being the gold standard for diagnosis and monitoring of periodontal disease.³ However, within the United Kingdom, for example, when a patient has a BPE of 4, we would go on to carry out a pocket probing depth chart and don't routinely record clinical attachment loss, making it difficult to implement the new classification. In 2018 the British Society of Periodontology (BSP) published a revised version of the 2017 classification to help steer practitioners through to diagnosing a patient using the 2017 classification system in a pragmatic way for general practice.⁴ This revised version is based mainly on radiographic bone loss⁵ and a flowchart was developed by BSP to aid NHS and private practitioners with implementing the 2017 classification.⁴

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The new classification brought about a few changes. The first change and one of the most profound is that it defined and recognised periodontal health for the first time.⁴ This was key as it meant many people who had gone without any periodontal diagnosis for many years after an examination would now have one. Recognising periodontal health ultimately allows for better lines of communication and a point of comparison if the patient ever develops periodontal disease in the future.

The extent of the disease is the same as before, with localised being less than 30% of the teeth being involved, and generalised, if it is more than 30%.⁴ However, there has been a reintroduction of molar/incisor pattern, which was the defining factor for juvenile periodontitis in periodontal classification used before Armitage 1999.⁶ The new classification also replaced the terms 'chronic' and 'aggressive' used in the Armitage model as periodontitis is a broad spectrum of a single disease, and not two distinct ones. There was also the addition of staging and grading the disease.⁴ Staging refers to the severity and is based upon the percentage of bone loss compared with the root length.⁴ The site with the worst amount of bone loss within the mouth due to periodontitis is used for this. The grading, however, determines the susceptibility of the patient to periodontitis. It predicts the presence of disease in the absence of treatment by comparing the percentage of bone with the patient's age.⁴ The terms 'staging' and 'grading' were taken from the model used to classify cancers and so some sensitivity needs to be used when discussing this with patients.

Evidence-based risk factors including smoking, sub-optimally controlled diabetes, pregnancy, stress, genetics etc, also need to be noted.⁴ This is a great addition as it allows clinicians to discuss these risk factors with the patient which could result in lifestyle changes and greater control of a patient's disease progression. The new classification means that clinicians can assess quickly at what stage their patient is in their pathway to achieving periodontal health by simply looking at the diagnosis.

Peri-implant disease also had its first appearance in the new classification⁵ and with the rise in the number of patients who have implants this was an important step to take. It allows clinicians to identify and therefore manage appropriately periodontal diseases and conditions associated with the placement of implants. These include peri-implant health, peri-implant mucositis and implantitis as well as hard tissue deficiencies.⁷

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It is crucial to remember that although the classification may have changed, the management is still the same.⁷ This includes carrying out bleeding on probing (BOP) and periodontal pocket depth (PPD) checks on patients who have been identified as having periodontal disease whether it is stable, in remission or currently unstable.⁷ Patients who then need treatment including supra and subgingival scaling and other non-surgical periodontal therapy (NSPT) should also be able to access this treatment.

The prevalence of severe periodontal disease worldwide ranges from between 10-15%.⁸ This is especially crucial as unfortunately litigation relating to mismanagement and misdiagnosis of periodontal disease continues to rise and the results to both the patient and the clinician can be devastating.⁹ When considering the top claims by value within the United Kingdom in 2015, 5.5% involved implants and periodontal disease, 28.8% involved just implants and 44.7% involved periodontal disease.⁹ The periodontal legal claims most frequently involved failure to diagnose by taking adequate radiographs to assess bone levels, evidence of risk assessment, monitoring or treatment of the disease.⁹ There are increasing claims for failure to offer specialist care and a failure to refer appropriately.⁹

Many simple steps can be implemented to avoid mismanagement of periodontal disease and litigation including explaining the diagnosis to the patient, constructing a long-term plan with the patient and documenting it. It is also important that, if working under a prescription by a dentist, the prescription is adequate. If this is not the case, then it should be discussed with the prescribing dentist prior to commencement of management and treatment. The new classification allows the ability to reach a diagnosis and lets the clinician know exactly where the patient is within the disease cycle, and this can help grant patients the best possible treatment for them.

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