
# Periodontal tips for primary care

**Ewen McColl**[1] continues our series of columns providing 'top tips' in dental specialties.

Periodontitis is a chronic multifactorial inflammatory disease associated with dysbiotic plaque biofilms, and characterised by progressive destruction of the tooth-supporting apparatus, which may ultimately result in tooth loss.[1] The balance between the oral microbiome and the host's immune-inflammatory response defence is a fine one, and central to preventing any imbalance is to give the patient the necessary information and tools to manage their own oral hygiene on a daily basis.

Gaining this cooperation is key, and many of my top tips relate to the patient's role in a shared approach between clinician and patient in improving and maintaining oral hygiene. This approach also fits with twenty-first century 'personalised medicine', which puts the patient at the centre of everything, and takes into consideration that the risk status of each patient differs. With regards to periodontitis, this individual risk status explains why some patients have significant periodontal destruction whilst others very little when exposed to similar bacterial challenge, as this is due to their individual immune responses to that challenge.

Behavioural change can be time-consuming, and the tips will hopefully help dental team members in primary care to be as efficient with their time as possible, accepting the time constraints and fiscal challenges that may present in primary care, particularly with regards to management of periodontal conditions.[2]

However, with an increasing awareness of the relationship between periodontal disease and systemic health, patients may be more receptive to changing behaviours to address their periodontal condition.

The aim of this short article is to present some clinical tips the author has found useful in managing periodontitis which will hopefully benefit colleagues. As a proviso, many tips have been gleaned from colleagues and adapted to my own practice (including 18 years as a Specialist Periodontist) with communication the key. They have worked for me and my patients but will of course need some adaptation to each individual clinician's circumstances, and patients' circumstances, with good communication always at the heart of managing our patients' oral health. I often reflect on ten things I wish somebody had told me at dental school that they never did – this would have saved me a lot of trial and error in practice, and I hope some of the below will be as helpful to colleagues as it has been to me.

## 1. Changing behaviour to optimise outcomes

The British Society of Periodontology S3 guidelines and flowchart ('BSP UK clinical practice guidelines for the treatment of periodontal diseases)[1,3] highlight the importance of patient-performed oral hygiene in managing periodontitis. Similarly, the CGDent *Standards in dentistry* document[4] highlights the importance of oral hygiene to all aspects of dentistry. The Scottish Dental Clinical Effectiveness Programme (SDCEP) Guideline, *Prevention and treatment of periodontal diseases in primary care*,[5] provides many useful practical tips for managing periodontitis in primary care, with improvement in the patient's own oral hygiene at the core of disease management.

A designated oral hygiene-specific session to go over all aspects of oral hygiene, allowing the patient to demonstrate what they currently do and what will be needed to improve, is time very well spent in my opinion. In discussing oral hygiene with our patients, the importance of interdental cleaning and supporting the patient to adopt this to become as routine as brushing is essential if disease is to be controlled.

It is important to explain to a patient the fact that interdental cleaning whilst more challenging is as crucial as brushing, but can take time – ie '*like cleaning a car – the outside is easier than inside, with the inside requiring more time, and more specific cleaning implements, just like interdental cleaning!*'

Much like with diet sheets, bespoke oral hygiene sheets can be developed and utilised to motivate patients to link their oral hygiene improvement to their own treatment goals (rather than our goals), which in the patient's case may be unrelated to control of periodontitis; ie to have restorations replaced to improve aesthetics. This may motivate patients to achieve their oral hygiene goal and clinically will also ensure the correct treatment strategy prior to moving to more advanced restorative care.

> 'The tips will hopefully help team members in primary care to be as efficient with their time as possible'

At the designated OH session, disclosing helps patients visualise areas they are missing and a try-in of sizes of interdental brushes can be important; ie '*like sweeping a chimney – if the brush doesn't touch the sides then it will have little effect*'.

Behaviour change[6] is of course a challenge on many occasions, and the BSP document highlights the engaging and non-engaging patient in recognition of the fact that despite our best efforts, for many reasons, patients may not be able to optimise oral hygiene and thus the compromises this may bring in optimising outcomes. It is important from a medico-legal perspective that this lack of progress is documented[7] to highlight we have tried, even if unsuccessful in changing behaviour in relation to oral hygiene.

## 2. Reducing risk factors

As alluded to above, wider awareness of the importance of the mouth as a window to the rest of the body can be emphasised to patients who often find this makes sense, as they can visualise change; ie a reduction in inflammation and bleeding on brushing. For example, the importance of smokers being given smoking cessation advice can be brought into context when explaining to patients the impact of ▸▸



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smoking on healing and vascularity of periodontal soft tissues.[8] This can help explain the wider effects; ie once you stop smoking, the tissues elsewhere will also start to heal and recover.

Similarly, I have had a number of patients over the years with poor periodontal conditions whom I have referred to their GP for diabetes testing and this has led to a diagnosis of Type 2 diabetes. This emphasis on the importance of oral health to general health often improves motivation and patients' willingness to take on board the wider health message, when they appreciate the significance of controlling periodontal health to general health.[9]

## 3. Instrumentation: don't blame your tools if you don't maintain them

Non-surgical periodontal therapy works,[10] but as with any other areas of dentistry, if you don't have the correct instruments for the job or don't maintain them, the outcomes will be much less likely to be successful. Ultrasonic instruments for effective supra and subgingival instrumentation should be well maintained, have a variety of tips available, and the instruments checked to ensure effectiveness. Don't just pick up any instrument and hope for the best. I know I used to!

It is similar with hand instruments. It is crucial to understand the ergonomics of the instruments not only for your and the patient's comfort but to ensure effective root surface debridement; ie tooth/area-specific instruments. For effective root surface debridement, instruments must be maintained and sharpened accordingly. Take the time to study and understand the instruments you use, and the benefits to your patients and your own professional satisfaction of a job well done will be a virtuous cycle for all concerned.

## 4. You've done the hard part!

Whilst in many cases the subgingival instrumentation (root surface debridement/subgingival professional mechanical plaque removal [PMPR]) can be the most demanding stage of treatment from both the patient's and the clinical team's point of view, it is crucial that this hard work is not lost by absence of appropriate recall, review and effective maintenance regime. Patients in my experience are receptive to a maintenance recall when they are educated on its importance in maintaining their hard-won periodontal health; ie '*Much as when an engine has an overhaul, the future servicing is crucial if a similar recurrence of engine failure is not to reoccur*'.

In my experience, the maintenance component as with every other stage of treatment is of equal importance and should not be overlooked. This stage is essential to not only reinforce oral hygiene, but to adapt oral hygiene to any changes to dental anatomy, restorations, implant placement or changes with patients' manual dexterity.[11,12] Similarly, the bespoke maintenance regime should target sites specifically with PMPR or root surface debridement where there are any signs of worsening of periodontal parameters. Recall intervals should be adapted to the patient's circumstances and the visit is more than a quick scale and polish but a key stage on a lifelong journey in the management of the patient's periodontal condition.

The above tips are clearly not a compendium of managing periodontal disease, and for this, the British Society of Periodontology have many reference sources offering a wealth of advice for screening, diagnosing and treating periodontal diseases in primary care. The above provides some top tips I hope readers will find useful in managing primary dental disease, crucial to all aspects of restorative dentistry, and increasingly our patients' general health. ■

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