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<th><strong>Title</strong></th>
<th>Life is like a box of chocolates: meeting the periodontal challenge</th>
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<tbody>
<tr>
<td><strong>Author(s)</strong></td>
<td>Roberts, Anthony</td>
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<tr>
<td><strong>Publication date</strong></td>
<td>2014-06</td>
</tr>
<tr>
<td><strong>Original citation</strong></td>
<td>Roberts, A. (2014) Life is like a box of chocolates: meeting the periodontal challenge, The Probe, 14 June, pp. 52-53.</td>
</tr>
<tr>
<td><strong>Type of publication</strong></td>
<td>Report</td>
</tr>
<tr>
<td><strong>Link to publisher's version</strong></td>
<td><a href="http://www.dentalrepublic.co.uk/the-probe">http://www.dentalrepublic.co.uk/the-probe</a></td>
</tr>
<tr>
<td>Access to the full text of the published version may require a subscription.</td>
<td></td>
</tr>
<tr>
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<tr>
<td><strong>Item downloaded from</strong></td>
<td><a href="http://hdl.handle.net/10468/2850">http://hdl.handle.net/10468/2850</a></td>
</tr>
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CSD/FMDis/FMDeb to reduce periodontal load in the various bacterial reservoirs in and gingivally with the aim of minimising the bacterial content. The discontinuous model where the disease activity increases sporadically over time. There will be periods of increased and decreased disease activity and progressive loss of attachment over time in an episodic manner. This pattern of disease is much less predictable. Ultimately, however, there are diverse groups of patients whose oral health behaves differently and it is very difficult – almost impossible – to predict how periodontitis will progress in individual patients.

Types of treatment

Currently, plaque biofilm disruption is the most effective way to treat and prevent both conditions, through mechanical and, where appropriate, chemical intervention. On a day-to-day basis, the emphasis is on the patient to affect their plaque biofilm removal or disruption using the variety of homecare products available. From a clinician’s perspective, in terms of scheduling treatment for patients with chronic periodontitis, there are three main approaches that have been implemented over the years:

- Conventional Staged Debridement (CSD), which involves scaling and root surface debridement in the shortest period of time and the use of chlorhexidine rinse on the tongue, fruits and subgingivally with the aim of minimising the bacterial load in the various bacterial reservoirs in and around the oral cavity.
- Full Mouth Debridement (FMDa), which is essentially the same as the FMD0s approach, but without the adjunctive use of chlorhexidine.
- Which treatment regime is best for patients with chronic periodontitis? Thankfully, all of the modalties achieve much the same outcomes. FMD0s and FMDa do offer slightly better statistical results, but whether they are clinically significant is debatable. Therefore, these different treatment modalities may be recommended for chronic periodontitis (without preference), provided adequate preventive measures are provided adequate preventive measures are provided. A different conclusion is conferred to patients with aggressive periodontitis where FMDa has the advantage of using systemic antibiotics is currently advocated as the preferred non-surgical treatment modality.

Outcomes of treatment

Treatment outcome is dependant upon many factors, including the extent of the initial pathology, patient compliance and treatment quality. Local anatomy is highly significant, for example, a supragingival implant in an edentulous site (with no significant bone loss). Outcome research is ongoing. A common problem is the difficulty of developing specific examples of periodontal risk assessments/calculators. Nonetheless, it may be possible to use those factors together in a form that is understandable to dentists and patients alike, enhancing the importance of managing periodontitis by preventing it before it starts (www.prevent.co.uk).

How will periodontitis progress?

There are two predominant models of disease progression, the discontinuous and the continuous models. The former assumes that there are two patterns of disease progression.

1. The linear model involves a slow continuous progression, which is relatively predictable.

2. The continuous model where the disease activity increases sporadically over time. There will be periods of increased and decreased disease activity and progressive loss of attachment over time in an episodic manner. This pattern of disease is much less predictable. Ultimately, however, there are diverse groups of patients whose oral health behaves differently and it is very difficult – almost impossible – to predict how periodontitis will progress in individual patients.

To conclude, there are a significant number of patients with chronic gingivitis and, given the consensus that the state has the potential for oral. The management of gingivitis patients should be a focus of attention. Positive improvements in periodontal health can be provided using a variety of home care products, primarily affecting the dental plaque biofilm is key. Unfortunately, the pathogenesis of periodontal disease is complex, and while there are tools to assist clinicians to predict those individuals who are likely to have periodontitis, there is currently no crystal ball that is 100 per cent accurate. As a consequence, patients with periodontal disease need to be managed on a case-by-case basis. The viable health checks on a case-by-case basis. 

PROFESSOR ANTHONY ROBERTS on why managing patients with perio disease is akin to delving into a box of chocolates – you never know what you’re going to get...

Life is like a box of chocolates: meeting the periodontal challenge

In 1979, the American Heart Association (AAAA) indicated that the number of people aged 55 and over who are edentulous has reduced from circa 75 per cent in 1979 to less than 25 per cent, hopefully due in no small part to improvements in the quality care we provide our patients. Clearly, not all of the teeth lost are solely due to periodontal disease, but the ADA Survey tells us that approximately 50 per cent of the population has an inflammatory disease affecting the periodontal tissues. In addition, over 45 per cent of Chilean male periodontal (gum) patients were wearing crowns and/or bridges (above or below the gum line). Unfortunately, some of these teeth will be lost. The conclusions we can draw from the ADA Survey in periodontal tissue are as follows:

- Periodontal disease remains common at a low level.
- Dental, a reduction in most adults and children.
- There is a shift in the prevalence of more severe disease.
- Gingivitis and periodontits indicate that the number of people aged

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