Perio 1 steps:

- Go through med Hx, CRA, Dental Hx and case present
    - Smoking status?
    - Ask if any teeth have been extracted due to mobility (must be due to mobility to classify it as periodontic tooth loss)
    - Ask when last dental visit was, when last cleaning was, how often they went for cleanings & check ups
    - OH habits: ask patient what kind of toothbrush they use, if they bleed when they brush and if so where/how often.
- Al Osman will checked gingival description, mobility, probing depths, furcation involvement, recession, adequate gingiva, vestibular depth
- For debridement, only one partner needs to be present. But at the case presentation and re-eval appt, Both need to be present

- Rule of thumb: canines and premolars are most susceptible to recession. So if you see recession in these areas, check if there is adequate keratinized gingiva
- If you see blue/red papilla, use floss and see if there is an open contact. Localized areas with this colouration usually indicates food impaction. Would expect to see deep probing depths in these spots
- Vestibular depth: sites to measure are the buccal of posterior teeth in mandibular (bc of the oblique ridge) or in any areas with severe recession (bc you will have shallow vestibular depth)
- Thick vs Thin Biotype:
    - stick a probe in and see if it shows through the gingiva. if you can see through then it is thin
    - If they have shorter interdental papilla = flat
- Mobility: premolars, molars, canines = lots of pressure because won't show physiologic mobility.
- Furcation involvement:
    - if CAL is is greater than root trunk height, good idea to check for furcation involvement
    - Avg root trunk = 3-5mm for max; 2-4mm for mand molars
    - Avg root trunk on mand molars is 1mm shorter in the buccal than the lingual
    - Max molars have approx 0.5mm difference between the buccal and lingual
    - Mark lingual furcation involvement with the "upside down triangles… V "

- If the patient has deep probing depths on distal of 7, need to ask if they had surgical removal of impacted 8s. If 8s removed before 25, likely no residual deep pockets but after 25, bone doesn't heal as well so they could have a residual pocket. If they have a residual pocket, this is NOT considered as periodontitis

Overall Outcome vs Individual Outcome

- can have a favorable overall but, individual teeth can be questionable or hopeless
- if teeth have furcation involvement (class 2 or 3), mobility, deep probing depths (7mm or more) = questionable or unfavorable. Which prognosis selected depends on how much furcation/mobility/deep PDs tooth has

Prognosis should be re-evaluated periodically.

Primary vs Secondary Occlusal Trauma:

- primary occlusal trauma = excess occlusal load on normal teeth
- Secondary occlusal trauma = normal occlusal load on perio compromised teeth

Primary etiology is always: bacterial biofilm in a susceptible host

Local Factors vs Prognostic Factor:

- prognostic factors contribute to the prognosis of the disease (eg deep probing depths, furcation involvement)
- Local risk factors contribute to the initiation of the disease (e.g cervical enamel extension)

When should you recommend floss vs a proxi-brush?

- if patient has black triangles, blunted papilla = proxi brush
- Soft tissue fills the interdental area (ie scalloped) = floss
    - GM-CEJ measurements in this region should be a negative number

Diagnosis:

- Generalized vs localized: <30% then its localized.
- If the radiographs demonstrate “crater form” bone loss, the B&L bone might be hiding what’s going on so default grading is Grade B
- If radiograph shows some widened PDL, can explain tooth mobility observed clinically. This could be due to occlusal trauma
- How to state the Dx: Localized/Generalized Stage ___ Grade ___ Periodontitis

Treatment Planning:

- If they smoke, #1 thing on tx plan is smoking cessation counseling
- Perio debridement is done before any caries control, endo, extractions (scaling done for teeth that will not be extracted)
    - If patient is in pain, then endo can precede perio debridement
    - If there is large piece of calculus on teeth to be extracted, debridement before bc want to make sure calculus doesn’t get into the pocket and for forceps to better grasp
- Do you think the patient needs a chlorhexidine mouth rinse as an adjunct tx? what about systemic antibiotics?
    - For mouthwash, if they have localized erythema, might be an indication for the rinse
- Re-evaluation post debridement: 4-8weeks
    - How do you determine if you will need to see them in 4 weeks vs 8 weeks?
- Maintenance phase - interval will be determined at the re-eval phase
- Surgical phase? also will be determined at re-eval phase

EXAMPLE:

1. Smoking Cessation Counseling

2. OHI
3. SRP
4. Caries Control/Exo of teeth ____
5. Re-Eval @ ___ wks
6. Surgical Phase: TBD @ re-eval
7. Maintenance Phase: TBD @ re-eval

Danas Notes

Important questions to ask your patient

- Do you bleed with brushing/flossing or both?
- In specific areas or generalized bleeding?
- If the patient indicates they do bleed, check those areas and determine why they are bleeding in those areas
    - most of the time it will be due to an open contact that's causing the bleeding
- did you have a regular dentist you saw before coming here and did you go for cleanings regularly?
- if they are missing a lot of teeth, its important to distinguish are they missing them due to caries or perio? ask the patient did they have a lot of cavities/unrestorable teeth or were their teeth loose and then extracted?

Mucogingival assessment

- Keratinized tissue
    - If a tooth is in a labioversion this causes dehiscence and is most likely an area where youll see recession and inadequate attached gingiva
    - for eg if you have a 44 and 45 and the 45 is upright but the 44 is tilted labially and mesially then the 44 will most likely have inadequate attached gingiva
    - in a healthy periodontium that has well aligned teeth the labial of the canines and premolars in both the maxilla and mandible are the areas where you are most likely to have inadequate gingiva , so keep this into consideration when you see canines and premolars that are not well aligned. they are even more likely to have decreased attached gingiva
- Vestibular depth
    - if you have a mandibular wisdom tooth this area will most likely have a shallow vestibular depth
    - areas where teeth have severe recession, ie 6-7mm, these will have shallow depths
    - on the buccal aspects of the maxillary 6/7's if the persons zygomatic process is low this can cause a shallow vestibule so assess the base of the zygomatic process and see how low it goes

Furcations

- it is important to keep in mind the root trunk averages when assessing furcations
- ie if you have a root trunk that is 5 mm long you would need at least 5mm of CAL before you could get a furcation involvement
- note than there are short, medium and long root trunks
- in the mandibular molars short root trunks are 2mm, medium are 3mm and long are 4mm
- in the maxillary molars short root trunks are 3mm, medium are 4mm and long are 5mm

Diagnosis

When writing the diagnosis make sure to write if its generalized or localized periodontitis

Risk factors

- deep pockets, furcations and mobilities are prognostic factors

Tx plan template

Initial therapy

- patient education/OHI
- smoking cessation
- periodontal debridement
- modification of risk factors
- caries control
- non restorable/hopeless teeth extraction
- if prescribing mouth wash to the patient who doesn't have many teeth you can tell them to use a q tip and put the mouth wash on there and rub the wash on their gums/teeth and massage it in instead of telling them to gargle with It
- systemic antibiotics as an adjunct or chlorhexidine

Re-evaluation

- is usually 4-8 weeks
- in patients who have poorer periodontal health, we usually wait longer to do the re evaluation because it will take them longer to heal and with increasing age it takes longer to heal so would have a longer re eval time with older ppl
- in patients who don't have extremely deep PDs/not a lot of inflammation we can bring them back in 4 weeks time
- in reality, if your patient needs a lot of caries control/extractions we would not do the re evaluation until those were completed but in school those can take a long time so we do the re-evaluation in a span of 4-8 weeks
- if they just had gingivitis the re eval can be done in 2 weeks
- surgical phase and maintenance phase TBD at re eval
- at the re eval we can have pts who need surgery but they aren't ready for it because they still have inadequate OH, that's why its important to stress maintaining OH with the pt so we can proceed with the surgical phase
- reinforce home care at this appt and evaluate if the end points have been achieved
- if they have not à move onto phase 2 therapy
- if they have à maintenance